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FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 6 1 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE V. ABBOTT			2a. DATE OF DEATH MONTH DAY YEAR 12 31 86		2b. HOUR MIN 3 45 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1899		
6. AGE (IN YEARS (LAST BIRTHDAY)) 87		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		
12b. KIND OF BUSINESS OR INDUSTRY USF & G						
13a. STATE MD		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13d. STREET ADDRESS / ZIP CODE 3613 Kimble Rd., 21218						
14. FATHER'S NAME FIRST MIDDLE LAST James Birch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stapleton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214 16 3031		17. INFORMANT ADDRESS Mary Jackson, Balto., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (If any): _____ _____ _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 12/1/86 , to 12/31/86 , that (1) (we) lost saw the deceased alive on 12/31/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Carla A. Alexander MD		DEGREE MD		22c. DATE SIGNED 12/31/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR CARLA ALEXANDER MD		22e. ADDRESS TOWSON STELLA MARIS HOSPICE BALTO, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/5/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD						
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.		25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE Julia Swickard-Randall		
4905 York Road Balto., MD 21212						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

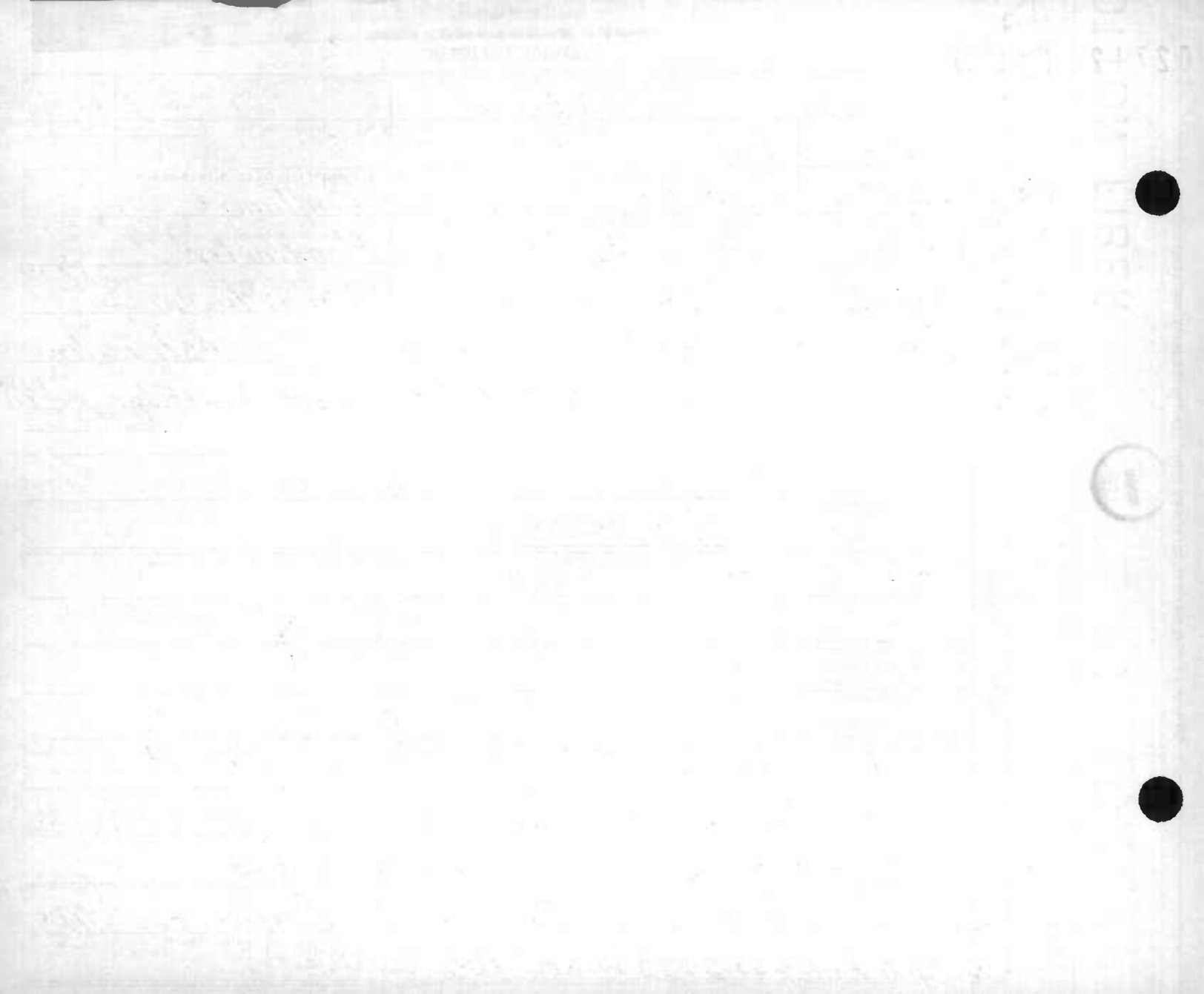
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) Gladys Adams			2a. DATE OF DEATH MONTH DAY YEAR 12 08 86			2b. HOUR 459 P.M.				
3. SEX Female		4. RACE Col		5. DATE OF BIRTH MONTH DAY YEAR 9-30 99		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY HAS ONE STREET ADDRESS) Baltimore Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1821 N. Mount St 21217				
14. FATHER'S NAME FIRST MIDDLE LAST Samuel CARR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Washington		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 250-30-0126		16c. INFORMANT Mr. William Adams 3611 Edgewood Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF (b) Gram Negative Bacteremia DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ① D.M @ Hypertension ③ #										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from 12/28/86 to 12/08/86, that (I) (we) lost saw the deceased alive on 12/08/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. ELNOUR			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/15/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ELNOUR			22e. ADDRESS 6401 Old Court Rd							
23a. BURIAL, CREMATION, REMOVAL (CHECK IF) Burial			23b. DATE 12-12-86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md			
24. FUNERAL DIRECTOR NAME Joseph L. Russ 2552 W. North Ave.			25a. DATE REC'D. BY REGISTRAR DEC 12 1986			25b. REGISTRAR'S SIGNATURE				

BP



027522 DEC 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 0 2

REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERMA BANKARD ALEXANDER			2a. DATE OF DEATH MONTH DAY YEAR 12-9-86			2b. HOUR 935 PM		
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR 8 25 1907		
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			7. BALTIMORE CITY OR COUNTY OF DEATH BALTO County MD.			8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			9b. CITIZEN OF WHAT COUNTRY? USA			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pickersgill			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROF. MUSICIAN		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE 615 Chestnut Ave. 21204			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WM ALBERT ALEXANDER ADYTH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST L. BANKARD			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 216-32-6721A			17. INFORMANT Pickersgill Home			17. ADDRESS 21204 615 Chestnut		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION 12-9-86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Stroke			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (was hospital) attended the deceased from June , 19 85 , to 12-9-86 , that (I) (was not) saw the deceased alive on 12-2-86 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was not) did not view the body after death.								
22b. SIGNATURE Keith A. Manley DEGREE MD						22c. DATE SIGNED 12-10-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith Manley, M.D.						22e. ADDRESS Pot Spring Rd., Timonium, Md. 21093		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-12-86			23c. NAME OF CEMETERY OR CREMATORY Parkwood		
23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.			24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			25a. DATE REC'D. BY REGISTRAR DEC 15 1986		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall								

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified.

026491 DEC-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEAN C. ALEXANDER			2a. DATE OF DEATH MONTH DAY YEAR 12 7 86		2b. HOUR 12 52 ^A M
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 27 31	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN		12b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CO.
13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE ANDERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN AVERY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 459-44-4724		17. INFORMANT MR. BALTIMORE, MARYLAND CASTOMAL ALEXANDER, SR. 1213 COBB ROAD 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK, HYPOTENSIVE DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED PYLORIC CHANNEL + DUODENAL ULCERS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 1-3 DAYS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: DIFFUSE LARGE CELL LYMPHOMA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from FALL 1986, to 12/7 1986, that (I) (we) last saw the deceased alive on 12/7 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b. SIGNATURE JAMES W. EAGAN, JR. M.D.		DEGREE M.D.		22c. DATE SIGNED 12/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EAGAN, JR. M.D.		22e. ADDRESS DEPT. OF PATH, ST JOSEPH HOSP, TOWSON.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/1986		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		25a. DATE REC'D. BY REGISTRAR DEC 8 1986			
24. FUNERAL DIRECTOR'S NAME NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY BALTO, MD. 21216		25b. REGISTRAR'S SIGNATURE Julia B. Ricketts			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove contents of pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP

027439

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 33623

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH		ESTIMATED	MONTH	DAY	YEAR	2d. HOUR
		SAMUEL H. ALTHOFF											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH					
Male	White	March 3, 1920	66 YRS.	Maryland	U.S.A.			Baltimore County					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Pikesville	7608 Lorry Lane	Administrator		Hospital									
13a. STATE	13b. CITY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS									
Maryland	Baltimore	Pikesville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7608 Lorry Lane		21208							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Samuel H. Althoff,		Anna Schilling											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW II		216-03-5464A		Sara B. Althoff - same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 (OTHER SIGNIFICANT) CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION									
				CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Title (SPECIFY) _____ MEDICAL EXAMINER													
ACTUAL SIGNATURE		DATE SIGNED											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
STANLEY Z. February, MD		11 E. Church St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Cremation		12-12-86		Westview Crematory		Balto.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME		ADDRESS		1050 York Rd.		DEC 15 1986		Julia Davidson-Randall					
Ruck Towson Funeral Home, Inc.		Towson, Md. 21204											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33624

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETHEL G. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR December 23, 1986			2b. HOUR 8P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 12, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4900 Stafford Street 21229	
14. FATHER'S NAME FIRST MIDDLE LAST George F. Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Silwright							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-46-2172		17. INFORMANT Woodrow Anderson		ADDRESS 6115 Johnnycake Road Baltimore, MD. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>APPRX. 5 days</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHRONIC CONGESTIVE CARDIAC FAILURE</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <u>1980</u> to <u>Dec 23</u> , 19 <u>86</u> , that (I) was last saw the deceased alive on <u>Dec 23</u> , 19 <u>86</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.										
22b. SIGNATURE <u>Edgar P. Williamson</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/24/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar P. Williamson M.D.			22e. ADDRESS # 5			5550 Baltimore National Pike, Baltimore, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/27/86		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Maryland		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 1630 Edmondson Avenue, Catonsville, MD. 21228						25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 33625
1. DECEASED NAME FIRST MIDDLE LAST
Andrew H. Anton
2a. DATE OF DEATH MONTH DAY YEAR
December 20, 1986
2b. HOUR
3:45P M

3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
5 5 1901
6. AGE (IN YEARS LAST BIRTHDAY) 85
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD.
10. CITY OR TOWN OF DEATH Catonsville 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Frederick Villa Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab Technician 12b. KIND OF BUSINESS OR INDUSTRY McCormick

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. CITY BALTO. 13c. CITY TOWN BALTO.
13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE
127 Regester Ave. 21212

14. FATHER'S NAME FIRST MIDDLE LAST Adam Anton
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Huffnagel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no 16b. SOCIAL SECURITY NO. 215-05-4773 A 17. INFORMANT ADDRESS
Mrs. Maria E. Sauter 127 Regester Ave 21212

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASOVID
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
① Family ② Delayed death

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [Signature] DEGREE AN D. 22c. DATE SIGNED 12/22/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] 22e. ADDRESS 5411 Old Frederick Road

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 12/23/86 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md.

24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home ADDRESS 6500 York Rd. 25a. DATE REC'D BY REGISTRAR DEC 30 1986 25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please contact the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

33823

105-1438

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33626

REG. NO.

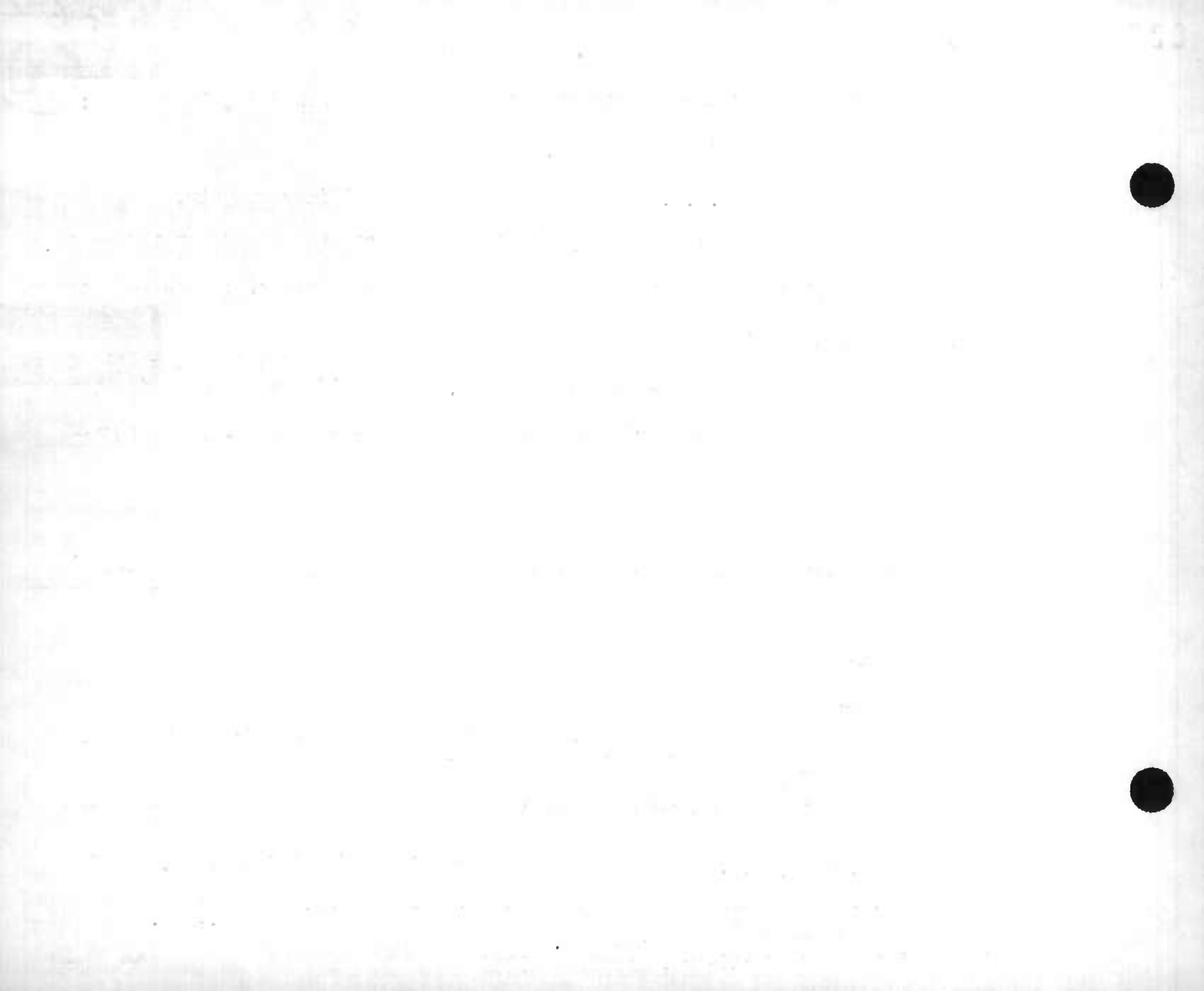
1. DECEASED NAME (TYPE OR PRINT) John Edward ANUSZEWSKI			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1986			2b. HOUR 11:08A _M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Teledyne Co.	
13a. STATE Maryland					13b. CITY OR TOWN Belmar		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Frank Anuszewski					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kurek				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Baltimore, MD 21206 John E. Anuezewski, Jr 6023 Mannington Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerosis Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1974	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <i>Small cell ca of lung. under chemotherapy.</i> 81-20-F6									
19a. DATE OF OPERATION <i>NA</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-16-74</i> , 19 <i>74</i> , to <i>12-14</i> , 19 <i>86</i> , that (we) last saw the deceased alive on <i>12-14</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John C. Hyle</i>				DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Hyle, M.D.				22e. ADDRESS 7527 Belair Road Baltimore, MD. 21236					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD.			
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, Maryland 21206				25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE <i>John T. Davidson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then photographs can be taken. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or what traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <u>Velma V. Appel</u>			2a. DATE OF DEATH MONTH <u>12</u> DAY <u>30</u> YEAR <u>1986</u>		2b. HOUR <u>3:15 AM</u>		
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>Jan</u> DAY <u>31</u> YEAR <u>1921</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO COUNTY</u> MD.	
10. CITY OR TOWN OF DEATH <u>TOWSON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Stella Maris Hospice</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housekeeper</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Maryland</u>		13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE LAST <u>Vogelman</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Ethel</u> MIDDLE LAST <u>Ortel</u>		13e. STREET ADDRESS / ZIP CODE <u>2306 Cloville Avenue 21214</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>212-14-8229</u>		17. INFORMANT ADDRESS <u>Louise A. Smeak 2306 Cloville Ave. 21214</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca lung with BRAIN Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> 19 <u>86</u> to <u>12-30</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Carla S. Alexander</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/30/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carla S. Alexander, M.D.</u>		22e. ADDRESS <u>Stella Maris Hospice</u>		22f. ADDRESS <u>Dulaney Valley Rd. - Towson, MD 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Dec 2 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck, Inc.</u> ADDRESS <u>Baltimore, Maryland</u>				25a. DATE RECD. BY REGISTRAR <u>DEC 31 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Tindem-Rudner</u>	

8327 DEC 29

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **86 33628**

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LOUISE AGNES ATKINSON		2a. DATE OF DEATH MONTH 12 DAY 20 YEAR 86		2b. HOUR 2:30 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 14 YEAR 1891		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.
7a. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk
13a. STATE Maryland		13b. COUNTY N.A.A.	13c. CITY OR TOWN Linthicum	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Jacob MIDDLE Peter LAST Franz		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Alice LAST Ingram		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-36-7508		17. INFORMANT ADDRESS George E. Atkinson 306 Jerlyn Ave. 21090
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE EVA DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD & CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) CHF AND PNEUMONITIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (I) (this hospital) attended the deceased from 11/4 19 86 , to 12/20 19 86 , that (I) (we) lost saw the deceased alive on 12/19 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE DR JOHN H. SHAW		DEGREE MD		22c. DATE SIGNED 12/22/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5800 EDMONDSON AVE BALTO MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/23/86	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION CITY OR TOWN Baltimore	COUNTY Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 22 1986
25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial-transit permit. Their place on the certificate should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

804-2-28

804-2-28

NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
AGNES C. AVILES				12 09 86				2:40am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasion		October 6, 1896		90 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		GBMC-6701 N. CHARLES STREET						Housewife.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6145 Northdale Road 21228			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Samuel R. Baxter				Kate Aubel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				214-38-0922		Mrs. Vivian Johnson		3526 Rolling Road Baltimore, MD. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) SUBARACHNOID BLEED											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
Anemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/09, 19 86, to 12/09, 19 86, that (I) (we) last saw the deceased alive on 12/09, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Vik Poonal						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
VIK POONAI, MD						GBMC-6701 N. CHARLES STREET					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		12/11/86		Loudon Park Cemetery		Baltimore City		COUNTY STATE Maryland			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133						DEC 12 1986					

028081 DEC 29 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33631

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Johnnie Preston BAINES			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1986		2b. HOUR 3:22 p.m.
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 5/25/19	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DURHAM, N. CAR.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LUTH. HOSPL.		12b. KIND OF BUSINESS OR INDUSTRY MANT.
13a. STATE MD.		13b. COUNTY BALTO	13c. CITY OR TOWN ROSDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BAINES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORA MAE BAINES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WWII 242-16-5114A		17. INFORMANT ADDRESS PAULETTE COMEGYS 3215 GWYNNS FALLS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from December 17, 1986, to December 17, 1986, that (he) (we) last saw the deceased alive on December 17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. H. R. H. D. S. M. D.		DEGREE MD		22c. DATE SIGNED 12/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEILA R. H. D. S. M. D.		22e. ADDRESS 9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/20/86		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.		25a. DATE REC'D. BY REGISTRAR DEC 21 1986			
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HEIGHTS		25b. REGISTRAR'S SIGNATURE Julia Anderson-Rodgers			

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REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

33632

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY A. BANES		2a. DATE OF DEATH MONTH DAY YEAR 11-27-86		2b. HOUR 6:00 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 10 05		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.
10. CITY OR TOWN OF DEATH PARKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE Md.	13b. COUNTY BALTIMORE	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 8903 B Walthamwoods Rd. 21234
FATHER'S NAME FIRST MIDDLE LAST Alfred Bowen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 177-30-8293	17. INFORMANT ADDRESS Bruce R. Banes (son) Baltimore Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF Cardiovascular disease years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SPACIL V. PATRICK		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 30-86	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Memorial Park	23d. LOCATION Clinton County Pa Dunnstable Twp	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES HARFORD		25a. DATE REC'D. BY REGISTRAR DEC 11 1986	25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, the medical examiner must be notified.

027512

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33633

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN BARD			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 10, 1986			2b. HOUR 2:25A _M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MARCH 24 th , 1906 th		6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY KNITTING & CHILDRENS WEAR	
13a. STATE MARYLAND			13b. CITY OR TOWN BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS SHIFREN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE UNKNOWN			13e. STREET ADDRESS / ZIP CODE APT. 204(21207) 7904 DUNHILL VILLAGE CIRCLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-46-7818		17. INFORMANT RUBIN BARD 11411 GLEN ARM RD. GLEN ARM, MD 21057				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Ischemic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Disease</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Diabetes Mellitus</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>G. V. Patterson</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. V. PATTERSON			22e. ADDRESS 2926 E. Collingwood Lane						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/11/86		23c. NAME OF CEMETERY OR CREMATORY BETH JACOB CEMETERY		23d. LOCATION FINKSBURG MARYLAND STATE		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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026476 DEC 19 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use on the burial-transit permit. Then please return this paper to the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic agent, the medical examiner must be notified to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LLOYD COLUMBUS BARKE						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6, 1986			2b. HOUR 1:23A M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 30 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A.M.C., FORT HOWARD, MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY ---					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WORCESTER 13c. CITY OR TOWN OCEAN CITY										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 891 Ocean Pines, 21811	
14. FATHER'S NAME FIRST MIDDLE LAST COLUMBUS BARKE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA PORTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Ruth E. Barke, 891 Ocean Pines, Berlin, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CARDIOMYOPATHY; S/P MYOCARDIAL INFARCTION; CHRONIC RENAL FAILURE</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 2</u> , 19 <u>86</u> , to <u>DECEMBER 6</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Bala S. Duggirala</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/6/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALA S. DUGGIRALA, M.D.					22e. ADDRESS V.A.M.C., FORT HOWARD, MARYLAND 21052								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/9/86		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,					ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33635

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mabel Marie Bates</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 31 86</i>		2b. HOUR 8:30P M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>9 22 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 98 Shipway / 21222			
14. FATHER'S NAME FIRST MIDDLE LAST <i>William LeBrun</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mellie Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219/12/5339		17. INFORMANT ADDRESS 21040 Howard F. Bates 607 Banyon Rd. Edgewood, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <i>Cerebro-vascular Arteriosclerotic Disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michael Schwartz</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/1/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Schwartz, MD				22e. ADDRESS 606 Hammonds Lane Balto., Md. 21225							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/1986		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21224			
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc., Balto., Md. 21222						25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be submitted to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

JAN 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thelma Ann BAUER			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1986		2b. HOUR 4:15P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 19, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN White Marsh	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Elmer L. Heath			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances T. Hallameyer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 219-03-4595		17. INFORMANT ADDRESS Rodney Bauer 3801 Belmont Dr. Jarrettsville MD 21084	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

15 min

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) Coronary Heart Disease

6 Yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertensive Cardiovascular Disease

20 Yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION -----	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Nov 19 83, to Dec 19 86, that (1) (we) last saw the deceased alive on Nov 21, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.			
22b. SIGNATURE Charles M. Kerr M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/26/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Kerr, M.D.		22e. ADDRESS 9618 Belair Road Baltimore, MD. 21236	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/29 /86	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD.
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc.		25a. DATE REC'D. BY REGISTRAR DEC 29 1986	
25b. REGISTRAR'S SIGNATURE Julia Davidson		25c. REGISTRAR'S SIGNATURE	
7110 Belair Road Baltimore, MD. 21206			

058150 10010

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows in several paragraphs]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1. STATE REGISTRAR		REG. NO. <u>B-1</u>	
1. DECEASED NAME (TYPE OR PRINT) <u>FRANK M. BAULER</u>		2a. DATE OF DEATH MONTH <u>12</u> DAY <u>17</u> YEAR <u>1986</u> 2b. HOUR <u>8.28 PM</u>	
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH <u>05</u> DAY <u>12</u> YEAR <u>1922</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	6. AGE YEARS (LAST BIRTHDAY) <u>64</u> YRS IF UNDER 1 YEAR: MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u> IF UNDER 24 HRS: MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>	
10. CITY OR TOWN OF DEATH <u>Balto</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Good Samaritan</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto</u> MD. 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>City Inspector</u> 12c. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>	
14. FATHER'S NAME FIRST <u>Matthew</u> MIDDLE <u></u> LAST <u>Bauler</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Hilda</u> MIDDLE <u></u> LAST <u>Weiner</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <u>214-16-6609</u>	
17. INFORMANT <u>Eva Bauler</u>		ADDRESS <u>4520 Ambermill Rd. 21236</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Pulmonary artery T</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>multiple metastatic cancer</u> DUE TO, OR AS A CONSEQUENCE OF } (c) <u>to Veterans and Am.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>			
19a. DATE OF OPERATION <u>11/2/86</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Coronary Stenosis and MI</u>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>86</u> , to <u>12/17</u> , 19 <u>86</u> . that (I) (we) lost saw the deceased alive on <u>12/17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>DR. NOLAN SOBUN</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>Good Samaritan Hospital Balto., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-22-86</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Maryland</u> STATE <u></u>	
24. FUNERAL DIRECTOR NAME <u>Hassanw Funeral Home</u> ADDRESS <u>1401 Belmar Rd BALTO. MD. 21236</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 19 1986</u>	
25b. REGISTRAR'S SIGNATURE <u>Li'a Anderson-Rodriguez</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33638

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNETTE M. BEISWANGER			2a. DATE OF DEATH MONTH 12 DAY 18 YEAR '86			2b. HOUR 9:35P ^M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 14 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY ^{MD.}			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) GMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Office	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 800 Mockingbird Lane 21204	
14. FATHER'S NAME FIRST William MIDDLE F. LAST Doehring					15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE Moser LAST Moser				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-20-8899		17. INFORMANT ADDRESS Gloria Roberts -106 Kenilworth Park Dr. 21204					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: CARDIOPULMONARY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) _____									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 86 , to 12/18 , 19 86 , that (I) (we) last saw the deceased alive on 12/18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K. Golnik				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. GOLNIK, M.D.				22e. ADDRESS GMC-6701 N. CHARLES ST.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-86		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS 1050 York Rd. Ruth Towson Funeral Home, Inc. Towson, Md. 21204						25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE Julia Tindon-Rudner	

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33639

REG. NO.

1. DECEASED NAME (FIRST MIDDLE LAST) <i>Singleton S. Bell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-30-1986</i>		2b. HOUR <i>9:45 AM</i>
3. SEX <i>MALE</i>	4. RACE <i>Col</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12-16-13</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTIMORE MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CO</i> MD.		
10. CITY OR TOWN OF DEATH <i>PANDALLSTOWN</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BALTIMORE CO GEN HOSP</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ISAIAH BELL</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>GERTRUDE DORSEY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>216036457</i>		17. INFORMANT ADDRESS <i>MR DOUGLAS BELL 3306 FIEROVILLE AVE 21207</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatitis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <i>Ascites, GI bleeding</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-23</i> to <i>12-30</i> , 19 <i>86</i> , that (I) (we) lost the deceased alive on <i>12-30</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Girgi</i>		DEGREE		22c. DATE SIGNED <i>12/30/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Girgi Raafat Girgi</i>		22e. ADDRESS <i>Baltimore County Hosp. Baltimore</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1-5-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NAT'L CEM</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MD</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>VASELY L. ROSS 2723 W. NORTH AVE</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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027192 DEC 16 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33640

1. DECEASED NAME (TYPE OR PRINT) Mayer J. Belt		2a. DATE OF DEATH MONTH DAY YEAR 12 - 10 - 1986		2b. HOUR 1047 M	
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 - 21 - 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, Co. MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co., Gen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Lee H Belt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah V. Hatcher		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 213-09-0840		17. INFORMANT ADDRESS Zena K Belt, 6708 Long Hill Rd. 21207	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electromechanical Dissociation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain stem stroke</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>86</u> , to <u>12-10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>William J. Chircus M.D.</u>		22c. DATE SIGNED <u>12-10-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William J. Chircus</u>		22e. ADDRESS <u>Belt County Gen. Hosp</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/15/86	23c. NAME OF CEMETERY OR CREMATORY Woodlawn CEMetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md
24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave.		25a. DATE REC'D. BY REGISTRAR DEC 15 1986	25b. REGISTRAR'S SIGNATURE <i>John D. ...</i>

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33641

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SEBASTIAN BERADUCCI			2a. DATE OF DEATH MONTH DAY YEAR 12 19 '86		2b. HOUR 8:07P M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR may 31, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 54 44 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) GMC-6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Correctial Off.		12b. KIND OF BUSINESS OR INDUSTRY M.C.I.J.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Anne Arundel Pasadena		
14. FATHER'S NAME FIRST MIDDLE LAST Dominick Beraducci			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Santa Cubeta		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1961 019326104		17. INFORMANT ADDRESS Carol Beraducci Same As # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b)	
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/10 , 19 86 , to 12/19 , 19 86 , that (I) (we) lost saw the deceased alive on 12/19 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jeffrey Foss M.D.</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY FOSS, M.D.		22e. ADDRESS GMC-6701 N. CHARLES ST.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec, 23, 86	23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cem Crownsville	23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A.A. MD.
24. FUNERAL DIRECTOR NAME McCully Funeral Home		25a. DATE RECD. BY REGISTRAR DEC 30 1986	
ADDRESS PASADENA, MD 21122		REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

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WILLIAM D. ROBERTSON, JR.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33642

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Marie L. Berg			2a DATE OF DEATH MONTH DAY YEAR 12 15 86			2b HOUR 12³⁰ A M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 9 18 1926		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH PERRY HALL		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9006 Hines Rd. Balto., Md.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Homemaking	
13a STATE MARYLAND			13b COUNTY BALTIMORE		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST George Dorbert			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Blunt			13e STREET ADDRESS / ZIP CODE 9006 Hines Rd. Balto. Md. 21234			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 212-22-3054		17 INFORMANT ADDRESS William M. Berg 9006 Hines Rd. 21234					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Hypokalemia Hyponatremia Anemia & Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Multiple strokes, Aphagia, Aphasia - Gastrointestinal partial ileus DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition Repeated aspiration pneumonias									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Tracheostomy - Constant oxygen - Gastrostomy & Constant tube feeding									
19a DATE OF OPERATION Dec 85			CONDITION FOR WHICH OPERATION WAS PERFORMED trachea aphagia & diaphragm			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from Aug 77 to Dec 86 , that (I) (we) most saw the deceased alive on 12/12/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE Frank T. Kasik, Jr.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/15/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Frank T. Kasik, Jr. 665-8692			22e ADDRESS 9005 Harford Rd. Balto., Md. 21234						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-17-86		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24 FUNERAL DIRECTOR NAME Lassahn Funeral Home			ADDRESS 1401 Belair Rd. BALTO. MD. 21236			25a DATE REC'D. BY REGISTRAR DEC 16 1986		25b REGISTRAR'S SIGNATURE Lia Gordon-Randall	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please send this certificate, page 4, to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 48 is any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

1- FOR
STATE
REGISTRARHELEN T.
BERKEBILESTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33643

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen T. BERKEBILE			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1986			2b. HOUR 4:16a M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 04 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTRAR		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7916 ROSELAND AVE 21237	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID --- SNEDDON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENEVIEVE ---					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) n/a		17. INFORMANT ADDRESS ROBERT C. BERKEBILE 7916 ROSELAND AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u> <u>Immed</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from <u>NOT SEEN FOR YEARS</u> , 19____, that (a) (we) last saw the deceased alive on <u>YEARS AGO</u> , 19____, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>JB Littleton MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-10-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JB LITTLETON						22e. ADDRESS 1012 Old North Point Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/12/86		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD		
24. FUNERAL DIRECTOR <u>[Signature]</u>						25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

0591



EX-100

029381 JAN 6 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) YETTA Berman			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1986			2b. HOUR 9:12 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 17, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH OWINGS MILLS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS) 128-B HARRY LANE 21117		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING	
13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN Berman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELIA SHERMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-0471A		17. INFORMANT ADDRESS MRS. REWA HOFFMAN 182B HARRY LA. OWINGS MILLS, MD 21117					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.U.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>Immediate</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alcohol, Neurologic Degeneration</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 72</u> to <u>12/29</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept. 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Morton J. Ellin</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/29/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORTON J. ELLIN MD		22e. ADDRESS 5310 Old Court Rd. Randallstown 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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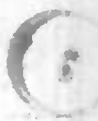
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33645

027437 DEC 17 1986

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALLEIN L. BEVERIDGE			2a. DATE OF DEATH MONTH DAY YEAR December 9, 1986			2b. HOUR 10:05pm			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 15, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Sparks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2407 Benson Mill Rd. 21152	
14. FATHER'S NAME FIRST MIDDLE LAST George Schwartz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Byrn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-0929		17. INFORMANT ADDRESS Jacquelyn Creswell - same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cremia DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Beventricular Failure Intractable Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary Artery Disease Hypertension								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 5 yrs 6 mos.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 2/8 , 19 54 , to 12/9 , 19 86 , that (I) (we) lost saw the deceased alive on 12/9 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William Benson M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 12/11/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Benson, M.D.				22e. ADDRESS 3506 N. Calvert St., Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-86		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not seen" it shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]



[Extremely faint and illegible handwritten text, likely a memorandum or report body.]

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027307 DEC 68

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div>FOR STATE REGISTRAR</div> <div>REG. NO.</div>										
1. DECEASED NAME (TYPE OR PRINT) Ruth Evelyn Bishop					2a. DATE OF DEATH 12 13 86		2b. HOUR 2:40 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 04 04 04		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TOWSON Baltimore Co. MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EDENWALD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Edwin Eugene Biscoe					15. MOTHER'S MAIDEN NAME Alice carter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-09-7010		17. INFORMANT Gordon D. Fronk		8308 Thornton Rd. Towson, Md. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>68</u> , to <u>Dec 13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on above (I) (we) did not view the body after death.										
22b. SIGNATURE <u>[Signature]</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-13-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. DAVID MAYER, MD				22e. ADDRESS 1205 York Rd.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION Baltimore City, Maryland				
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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027140 DEC 5 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33647

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William E. Bishop</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-5-86</i>			2b. HOUR <i>07:10 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07-21-13</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>73</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD	
10. CITY OR TOWN OF DEATH <i>TOWSON MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Stock Clerk</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>BALTO.</i>		13c. CITY OR TOWN <i>TOWSON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph H. Bishop</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella E. Bishop</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>WVH 216-09-3886</i>		17. INFORMANT ADDRESS <i>Mrs. Susie J. Bishop 300 E. Pennsylvania Ave</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Acute CVA*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Severe ASCVD*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Cardiac arrhythmia*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE <i>Nestor Carmona</i>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NESTOR CARMONA</i>		22e. ADDRESS <i>6012 Hafnol Rd. Balto, Md. 21214</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12/11/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>David Ridge</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pikesville MD</i>	
24. FUNERAL DIRECTOR NAME <i>CHATMAN-HARRIS FH</i> ADDRESS <i>1701 McCulloh St</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 12 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Lelia J. ...</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William L. Blair			2a. DATE OF DEATH MONTH 12 DAY 9 YEAR 86			2b. HOUR 2:20 PM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 31 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO Co., MD.						
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL 7420 YORK RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Mfg.			
13a. STATE Md			13b. COUNTY BALTO		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 812 REGESTER AVE 21239			
14. FATHER'S NAME FIRST UNK MIDDLE UNK LAST UNK					15. MOTHER'S MAIDEN NAME FIRST UNK MIDDLE UNK LAST UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown			16b. SOCIAL SECURITY NO. 212 05 7356		17. INFORMANT ADDRESS Mrs. Dorothy E. Hawkins 111 9th Ave. 21225							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis.												
DUE TO, OR AS A CONSEQUENCE OF (c) Prostatic carcinoma.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12-9-86 to 12-9-86 , that (I) (we) lost saw the deceased alive on 12-9-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Adel S. El-Hennawy MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-9-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adel S-EL-Hennawy.						22e. ADDRESS SJH-						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/12/86		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Md.				
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.						ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

027308 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33649

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MICHAEL FRANCIS BLANEY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 13, 1986		2b. HOUR M						
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1948		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 33 Melken Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Appraiser		12b. KIND OF BUSINESS OR INDUSTRY MAIF			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Blaney						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Hartman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-52-9241		17. INFORMANT ADDRESS Charlotte Blaney Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Negative Autopsy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 y.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Med. Kine. Disease</u>											
19a. DATE OF OPERATION 1972				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1972</u> , 19 <u>86</u> , to <u>Dec 7</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Arthur A. Serpick</u>						DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/15/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur A. Serpick, M.D.						22e. ADDRESS 7620 York Rd. Baltimore, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE <u>Julia R. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33650

127525 DEC 1986

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Charles J. Blazek, SR.</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12 13 86</i>		2b. HOUR <i>5 40 PM</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 18 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Stella Maris Hospice</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Corps of Engineers-U.S. Army</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Timonium</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>6 Thaxton Ct. 21093</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Blazek</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Blazek</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>Yes WW I</i>		16b. SOCIAL SECURITY NO. <i>088-05-1209</i>		17. INFORMANT ADDRESS <i>Dr. Charles J. Blazek, Jr.-625 Lake Dr. 21204</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic squamous cell carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from <i>12/19</i> , 19 <i>86</i> , to <i>12/13</i> , 19 <i>86</i> , that (I/we) most saw the deceased alive on <i>12/13</i> , 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Eddie Nakhuda</i>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Eddie Nakhuda, M.D.</i>		22e. ADDRESS <i>Stella Maris Hospice Dulaney Valley Rd.-Towson, MD 21204</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12-16-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>DEC 15 1986</i>	
24. FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</i>		ADDRESS <i>1050 York Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Part 1) and it should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

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027584 DEC 19 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

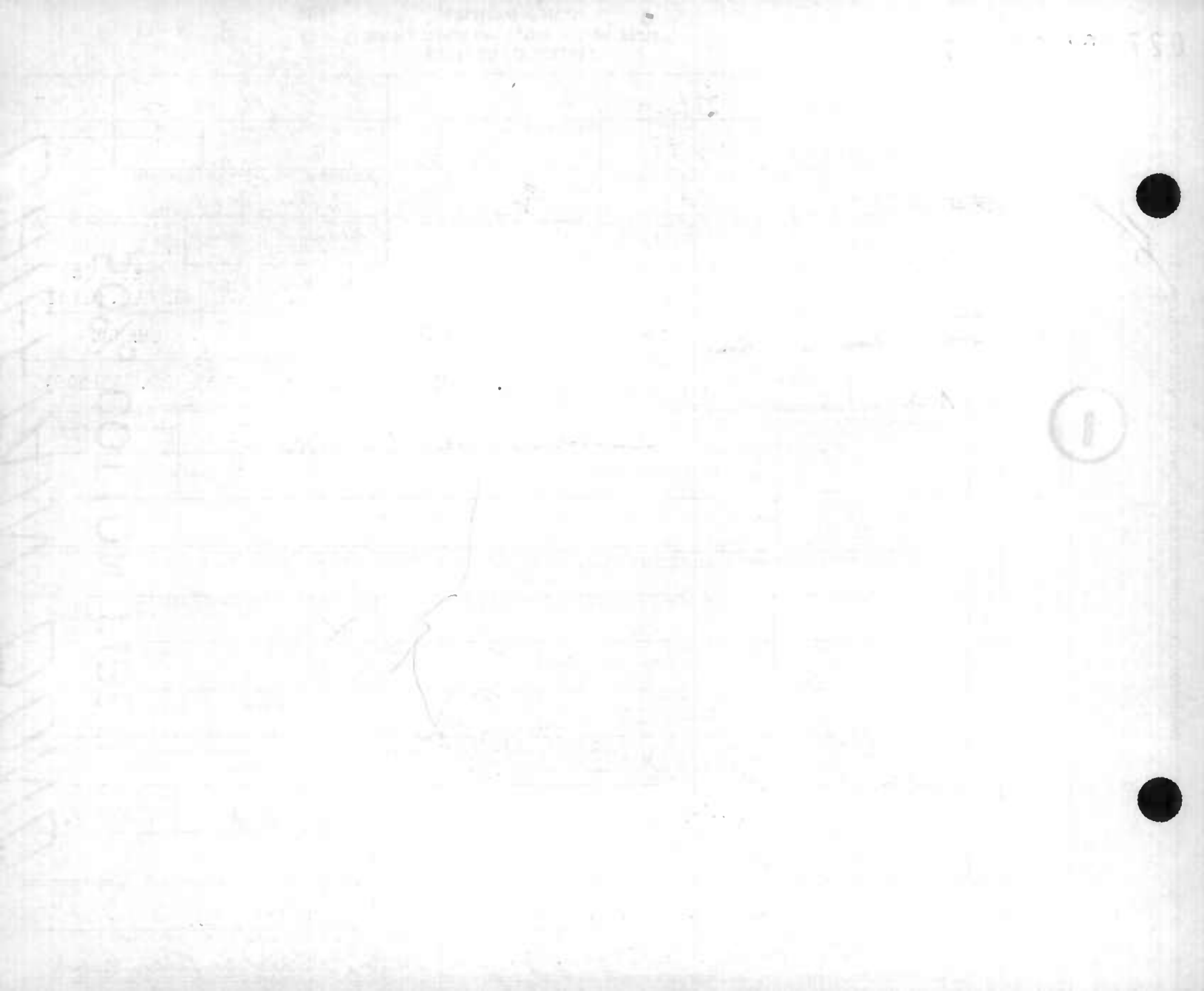
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Freda Blum			2a. DATE OF DEATH MONTH DAY YEAR 12 12 86			2b. HOUR 21:45^M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 16 92		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
13a. STATE MD		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Apt. 316 2500 W. BELVEDERE AVE. (21215)			
14. FATHER'S NAME ABRAHAM MIDDLE FINE				15. MOTHER'S MAIDEN NAME UNKNOWN MIDDLE UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-54-0422		17. INFORMANT ADDRESS DR. SIDNEY BLUM 711 CLIFFEDGE RD. (21208)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ST Bleeding ST Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Septic DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/12/86 8:35 AM to _____, 19____, that (I) (we) last saw the deceased alive on 12/22/86 @ 8:30 PM , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Gottlieb					DEGREE: ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gottlieb					22e. ADDRESS SINAI HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12/14/86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE, MD. COUNTY STATE		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)						25a. DATE REC'D. BY REGISTRAR DEC 16 1986			
						25b. REGISTRAR'S SIGNATURE Julia Tonderson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CASSIE William BOGGS			2a. DATE OF DEATH MONTH DAY YEAR 12-16-86			2b. HOUR 839 M			
3. SEX M Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-14-03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY Steel Mfrg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST H. G. Boggs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida F. (unknown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 235/10/7599			17. INFORMANT ADDRESS Joppatowne, Md. Jewell Black 609 Joppa Farms Rd. 21085						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of the prostate</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Natividad D. de Leon, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 12/17/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON					22e. ADDRESS c/o St. Joseph Hospital, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/19/1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem Gds.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford, Md.		
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Balto., Md. 21222					25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall		

MEDICAL CERTIFICATION

PROX COLICID FIBER

DATE: 12-14-68
TIME: 10:15 AM
BY: J. H. [illegible]

LOCATION: [illegible]
REMARKS: [illegible]

[Faint, mostly illegible handwritten notes and text, possibly describing a survey or inspection.]

DEC 18 1968

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Marie L. BOHLMAN			MONTH DAY YEAR 12 01 86			2206 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White	MONTH DAY YEAR Dec. 4 95	90 YRS.			MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Lithuania	USA				BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown	BALTIMORE COUNTY GENERAL			Button Hole Maker			Clothing	
13a. STATE			13b. CITY OR TOWN	13c. STREET ADDRESS				
Maryland			Baltimore	3 S. Beechfield Ave., Apt. A				
FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Stanislaus Luipater			Barbara UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No.			215-05-4241		Earl W. Bohlman, 15 Truckhouse Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Brain Coronary Occlusion</u>								3 min
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anemia and arteriosclerosis</u>								24 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastric ulcer - Bleeding</u>								3-4 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
12/1/86		Bleeding Gastric Ulcer			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1/86</u> 19 <u>86</u> , to <u>12/1</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>James J. Berman MD</u>						DEGREE		22c. DATE SIGNED
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/1/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
JAMES J. BERMAN MD						15 E. Eager St Balto Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation		12/4/86		Security Process Crem.		Catonsville Baltimore Md.		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hubbard Funeral Home, Inc., 4107 Wilkens Ave.				21229		DEC 3 1986 <u>John Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2, should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic cause, a medical examiner must be notified at once.

BP

01-04-1950

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages (1) and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 6 5 4

1. FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

William

A

BOLLINGER

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

12-

12

13

86

2P^M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

6

23

1917

6. AGE (IN YEARS LAST BIRTHDAY)

69

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTO County

MD.

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

STELLA MARIS HOSPICE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Foreman

12b. KIND OF BUSINESS OR INDUSTRY

Beth Steel

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5122 Pembroke Ave 21206

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Ernest

Bollinger

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Martha

Menold

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

W.W.II

218-03-4125

17. INFORMANT

ADDRESS

Irma Bollinger Same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) INTestinal obstruction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) ADENOCARCINOMA ABDOMINAL WALL

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-12, 1986, to 12-13, 1986, that (I) (we) last saw the deceased alive on 12-13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

12-13-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Eddie Nakhuda, M.D.

22e. ADDRESS

Stella Maris Hospice
Dulaney Valley Rd.-Towson, MD 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

Dec. 17, 1986

23c. NAME OF CEMETERY OR CREMATORY

Westview Memorial

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Catonsville Balto., Md.

24. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Baltimore, Maryland

25a. DATE REC'D. BY REGISTRAR

DEC 15 1986

25b. REGISTRAR'S SIGNATURE

John Anderson-Randall

057 17 10

Stationville, Pa. 15
Dec 17, 1946
Mr. J. H. ...
...

026579 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAULINE H. BOSLEY			2a. DATE OF DEATH MONTH DAY YEAR December 7, 1986		2b. HOUR 6 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 28, 1910		
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		8. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi-Medical Center		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STATE MD		
13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 3900 N. Charles St., 21218		14. FATHER'S NAME FIRST MIDDLE LAST John J. Horstman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Barth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Henry Busch, Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli, probable DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hodgkins Disease Severe Pt. Hemiparesis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (the hospital) attended the deceased from 3/11/83 to 12/7/86 , that (I) (we) lost saw the deceased alive on 12/6/86 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE William Benson Jr. D.		22c. DATE SIGNED 12/8/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William P. Benson, MD		
22e. ADDRESS 3506 N. Calvert St., Balto., MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/86		
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD		24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		
25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE Julia Tidwell-Randall				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be filed with this certificate.

02007 2111

U. S. H. Y. December 7, 1961

TO: Mr. J. Edgar Hoover, Director, FBI
FROM: Mr. J. Edgar Hoover, Director, FBI

Subject: [Illegible]
Reference: [Illegible]

John J. [Illegible]
[Illegible]



[Illegible handwritten or typed text]

*

Very truly yours,
[Illegible signature]
[Illegible title]
[Illegible address]

026251 DEC-9 86

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR A ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is only injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 0 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edith Marie BOWER			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1986			2b. HOUR 11:13p			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 21 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5503 GERLAND AVE 21206	
14. FATHER'S NAME FIRST MIDDLE LAST ELADEO ROBERT CROWSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RAEACHEL ANN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. n/a		17. INFORMANT ADDRESS LILLIAN HOOD 5503 GERLAND AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus; Parkinson's Disease; Cardiac Arrhythmias Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/19/80 to 12/5/86 , that (I) (we) last saw the deceased alive on 11/28/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Albert B Bradley				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Bradley, M.D.				22e. ADDRESS 4900 Belair Road, Baltimore, MD 21206					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/6/86		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD			
24. FUNERAL DIRECTOR John A. [Signature]				25a. DATE REC'D. BY REGISTRAR DEC 5 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE "CHIEF MEDICAL EXAMINER" ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR
Luke Streett Bowman, Jr.					12-19 1986					M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH		10. KIND OF BUSINESS OR INDUSTRY		
Male	White	4 27 15	71 YRS.	MONTHS	DAYS	Baltimore County, MD.		Quaker Oat Co		
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		12. CITIZEN OF WHAT COUNTRY?		13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.				Salesman		Quaker Oat Co		
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. CITY OR TOWN		20. STREET ADDRESS		
Towson		900 Stags Head Road		Maryland Balto.		Towson		900 Stags Head Rd. 21204		
21. FATHER'S NAME		22. MOTHER'S MAIDEN NAME		23. SOCIAL SECURITY NO.		24. INFORMANT		25. ADDRESS		
Luke Streett Bowman, Sr.		Anna L. Wheeler		218-07-0599		Mr. Donald Antos		Same as 13e		
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
Chronic obstructive pulmonary disease										
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					28. AUTOPSY?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
29a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		29b. TIME OF INJURY		29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
30a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		30c. LOCATION		CITY OR TOWN COUNTY STATE				
31. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
32. ACTUAL SIGNATURE		33. TITLE (SPECIFY)		34. DATE SIGNED		35. MEDICAL EXAMINER				
William M. Zane, M.D.		Assistant		12-20-86						
36. EXAMINER'S NAME (TYPE OR PRINT)		37. ADDRESS		38. DATE REC'D BY REGISTRAR		39. REGISTRAR'S SIGNATURE				
William M. Zane, M.D.		111 Penn St., Balto., Md. 21201		DEC 22 1986		Julia Tindon-Randall				
40. BURIAL, CREMATION, REMOVAL		41. DATE		42. NAME OF CEMETERY OR CREMATORY		43. LOCATION				
Entombment		12/22/86		Dulaney Valley Mem. Gdns		Tiftonium Balto. Md.				
44. FUNERAL DIRECTOR		45. ADDRESS		46. DATE REC'D BY REGISTRAR		47. REGISTRAR'S SIGNATURE				
Ruck Towson Funeral Home, Inc.		1050 York Rd.		DEC 22 1986		Julia Tindon-Randall				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies of Pages 1 and 2 and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, or medical condition, which may be related to the cause of death.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STANLEY BURNS BOWMAN, JR.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 22, 1986			2b. HOUR MIN. 7 22 A			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 06 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 12 22 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21239		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY BURNS BOWMAN, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH IRELAND				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 013-03-3520		17. INFORMANT ADDRESS ELEANOR M. BOWMAN 1005 REGESTER AVE. 21239				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant mesothelioma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Thrombocytopenia most likely secondary to Quinine.									
19a. DATE OF OPERATION 11/11/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left pleural effusion		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 86 , to 12/22 , 19 86 , that (I) (we) last saw the deceased alive on 12/22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eric Fisher MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC FISHER MD				22e. ADDRESS SAINT JOSEPH Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 24, '86		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE GAR. BALTIMORE CO., MD			
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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- Bottom right: "1000"



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be properly filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NORMAN L. BRADSHAW			2a. DATE OF DEATH MONTH DAY YEAR 12-14-86		2b. HOUR A 9:30 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 10, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Gen. Supervisor - Balto. G. & F.		
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1146 Glendale Rd. 21239		
14. FATHER'S NAME FIRST MIDDLE LAST John C. Bradshaw				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Perkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean		16b. SOCIAL SECURITY NO. 212-28-1299		17. INFORMANT ADDRESS Sarah G. Bradshaw - same as #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>86</u> , to <u>12/14</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/14</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>M. Eldeffawi</i>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/14/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MOSEN ELDEFFAWI				22e. ADDRESS GBMC 6701 N. CHARLES ST.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-86		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 18 1986 <i>Julius B. ...</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST JEROME		MIDDLE R. Obert		LAST BRANDT		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		12 5 19 86		2b. HOUR M 6:08 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 1, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 12 10 1986		7d. HOUR PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD							
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2120 Cameron Dr. Apartment 2A				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Steel Mfrgr.					
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 212202 2120 Cameron Drive Balto., Md.			
14. FATHER'S NAME FIRST MIDDLE LAST John Joseph Brandt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret George				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes					
16b. SOCIAL SECURITY NO. 1952-1956				17. INFORMANT Marie L. Hooks				17. ADDRESS 21220 1607 Burke Road Balto., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-11-86					
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Dec. 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc.				ADDRESS 2135 Dundalk Ave.				25a. DATE REC'D. BY REGISTRAR DEC 12 1986				25b. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME FIRST MIDDLE LAST OLIVER Winfield BRAUER		2a. DATE OF DEATH MONTH DAY YEAR 12 21 86		2b. HOUR 4:12A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ticket Agent		12b. KIND OF BUSINESS OR INDUSTRY Bus Co.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ewald Brauer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Weinreich		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 05 8842	
17. INFORMANT ADDRESS Evelyn Brauer, Wife		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/21 19 86 , to 12/21 19 86 , that (I) (we) last saw the deceased alive on 12/21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE J. E. Walters		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-21-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JESIE I. WALTERS M.D.		22e. ADDRESS GBMC 6701 N. CHARLES ST.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/86	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore Co., Md.		24. FUNERAL DIRECTOR Brzezinski Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 23 1986	
25b. REGISTRAR'S SIGNATURE Julia Davidson		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

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THE UNIVERSITY OF CHICAGO

026903 DEC 12 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

2a. DATE OF DEATH

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE

7a. BIRTHPLACE

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

12a. USUAL OCCUPATION

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS / ZIP CODE

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY?

19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

20a. ACCIDENT WAS UNDERLYING

20b. TIME OF INJURY

20c. HOW INJURY OCCURRED

21a. INJURY OCCURRED

21b. PLACE OF INJURY

21c. LOCATION

22a. I certify that

22b. SIGNATURE

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

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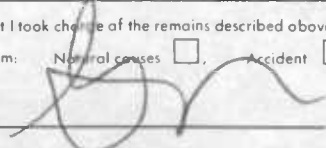
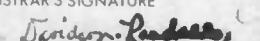
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026924 DEC 12 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Wayne		MIDDLE L.		LAST Breeden		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1952		6. AGE (IN YEARS) LAST BIRTHDAY 34 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR 9:50 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County									
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8502 Arry Place (front)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President		12b. KIND OF BUSINESS OR INDUSTRY Md. Nat. Bank									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5 Glenluce Ct.		21204					
14. FATHER'S NAME FIRST MIDDLE LAST Leander Breeden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna White											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 214-54-7386		17. INFORMANT Margaret E. Breeden - same as #13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Back</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 6:18 P.M. 12/7/ 19 86				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8502 Arry Place, Baltimore County, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12/8/86			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-10-86		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley				23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Rd. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 10 1986		25b. REGISTRAR'S SIGNATURE 					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in contact with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. If item 21 is marked or item 18 is marked, the medical examiner must be notified of the death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1 - FOR STATE REGISTRAR				3 3 6 6 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES P. BRENNAN				2a. DATE OF DEATH MONTH DAY YEAR 12-27-86	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 14, 1901	
6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FACTORY REP.	
12b. KIND OF BUSINESS OR INDUSTRY FARM EQUIP.		13a. STREET ADDRESS / ZIP CODE 10200 VIRGINIA AVE 21038		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN BRENNAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA KILBRIER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 215-8760		17. INFORMANT Family Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) NORMAL PRESSURE HYDRO-CEPHALUS DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-27-86 to 12-27-86, that (I) (we) last saw the deceased alive on 12-27-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Taavoni MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TAAVONI		22e. ADDRESS GBMC 6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12-30-1986		23c. NAME OF CEMETERY OR CREMATORY Green Mount	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		23e. DATE REC'D. BY REGISTRAR DEC 30 1986			
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES YORK ROAD		25b. REGISTRAR'S SIGNATURE John Brian P. P.			

8:30 12-27-86

BALTIMORE COUNTY

68MC-6701 N. CHARLES ST.

TOWSON

CARDIOPULMONARY ARREST

NORMAL PRESSURE HYDRO CEPHALUS

XX

12-27-86 86

12-27 86

68MC 6701 N. CHARLES ST.

DR. TAVONI

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST RUTH

MIDDLE TAYLOR

LAST BRICKER

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

10 54 M

3. SEX

Female

4. RACE

white

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

72 YRS.

7. IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

US (Md)

7b. CITIZEN OF WHAT COUNTRY?

US

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

County

MD.

10. CITY OR TOWN OF DEATH

Balti'

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

St Joseph Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Accountant

12b. KIND OF BUSINESS OR INDUSTRY

Telephone Co.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Baltimore

14. INSIDE CITY LIMITS?

YES ☒ NO ☐

15. STREET ADDRESS / ZIP CODE

4505 Arabia Ave. 21214

14. FATHER'S NAME

George

MIDDLE

LAST

Bricker

15. MOTHER'S MAIDEN NAME

Rose

MIDDLE

LAST

Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

212-01-6903

17. INFORMANT

ADDRESS

M.M. Hoshall 5470 Mersea Ct. Burke Va. 22015

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hepatic failure with secondary metastasis

DUE TO, OR AS A CONSEQUENCE OF

(b)

Metastatic cancer of stomach

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

ASCVD, COPD

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/22, 1986, to 12/6, 1986, that (I) (we) saw the deceased alive on 12/6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

MD

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/6/86

23a. PHYSICIAN'S NAME (TYPE OR PRINT)

HABERSAT (correction for Dr. Yorkoff)

23b. ADDRESS

214 Mt. Carmel Rd, Parkton 21120

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-10-86

23c. NAME OF CEMETERY OR CREMATORY

Loudon Park

23d. LOCATION

Baltimore

COUNTY

STATE

Maryland

24. FUNERAL DIRECTOR

NAME

Mitchell-Wiedefeld Home 6500 York Road 21212

ADDRESS

25a. DATE REC'D. BY REGISTRAR

DEC 11 1986

25b. REGISTRAR'S SIGNATURE

Deborah R. Rader

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "COPIES" and "RECEIVED" are visible.]



29362 JAN - 6

07- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARVIN HERMAN BRIDGES			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31, 1986		2b. HOUR 6:45PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 10, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.	
10. CITY OR TOWN OF DEATH 21204	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2 AIRWAY CIRCLE #3A 21204		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION
13a. STATE MARYLAND		13b. CITY BALTIMORE	13c. CITY OR TOWN 21204	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN BRIDGES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLY CALLIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS SHIRLEY S. BRIDGES TOWSON, MD 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William H. B. Howard</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H.B. HOWARD, M.D.		22e. ADDRESS 201 E. UNIVERSITY PKWY 235-9806			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) ENTOMBMENT		23b. DATE JAN. 3, '87	23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY, MD
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON		ADDRESS 8521 LOCH AVEN BLVD.		25a. DATE REC'D. BY REGISTRAR JAN 5 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, called in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having sharp injury, or other traumatic event, the medical examiner must be notified at once.

BP

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF LANDS
TO THE HOUSE OF REPRESENTATIVES
IN SENATE AND HOUSE OF REPRESENTATIVES
OF THE UNITED STATES
FOR THE YEAR 1902

WASHINGTON
GOVERNMENT PRINTING OFFICE
1903

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 5 6 7

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph Briscoe</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 14 86</i>		2b. HOUR <i>5:05 A</i>	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 18 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>71 YRS.</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bland Bryant Nursing Home</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>UNKNOWN/Retired</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Northeast, Md.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-165-912</i>		17. INFORMANT ADDRESS <i>Office of Aging</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Schizophrenia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>mental retardation.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>12-02-1978</i> to <i>12-14-1986</i> , that (I) (we) last saw the deceased alive on <i>12-14-1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>H. Deradoss</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/14/86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. Deradoss MD</i>				22e. ADDRESS <i>BBNH. SGT C.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/22/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landsdown Md</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>March Funeral Home West 4300 Wabash Avenue</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER



1

29032 JAN - 5 1998

Film G623 item 17

FOR STATE REGISTRAR
1/16/98 per F.H. rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLOSSIE M. BROOKS			2a. DATE OF DEATH MONTH DAY YEAR December 30, 1986		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 15, 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 86	IF UNDER 1 YEAR IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holly Hill Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 115 Tenbury Road 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph William Lewis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mittie Ann Jenkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-09-0706		17. INFORMANT Warden ADDRESS Mrs. R. Beatrice Warren same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Brain DUE TO, OR AS A CONSEQUENCE OF (b) Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Many years. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 86 , to 12/30 , 19 86 , that (I) (we) last saw the deceased alive on 11/11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE for Marc I. Levi, M.D.		DEGREE Attending Physician		22c. DATE SIGNED 12/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) for Marc I. Levi, M.D.		22e. ADDRESS 7600 Osler Drive Suite 315			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/86	23c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Road			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 31 1986 Julia Swenson-Randall		

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Amelia A. Broughton</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12 25 86</i>			2b. HOUR <i>12 55 AM</i>			
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 1 94</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3530 E. Northern Pkwy. 21206</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Fulda</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fannie Dulaney</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-07-7067D</i>		17. INFORMANT ADDRESS <i>Dolores N. Knighton 3503 Northern Pkwy</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <i>① Pneumonia ② Congestive heart failure</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>9-22</i> , 19 <i>86</i> , to <i>12-25</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12-19</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Marion C. Kowalewski</i> MD						DEGREE <i>MD</i>		22c. DATE SIGNED <i>12-26-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Marion Kowalewski</i>						22e. ADDRESS <i>8604 Harford Rd 668-7030</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec 29 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc.</i>						ADDRESS <i>Baltimore, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 29 1986</i>		
						25b. REGISTRAR'S SIGNATURE <i>Anderson-Randall</i>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR

2a. DATE OF DEATH MONTH DAY YEAR December 18, 1986 2b. HOUR 6AM

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR April 30, 1886 6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. 10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY ---

13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE 602 Lake Drive 21204

14. FATHER'S NAME FIRST MIDDLE LAST Unknown 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 262-80-7124 17. INFORMANT ADDRESS Dr. G.H. Brouillet 6148 Lanfair Dr. 21044

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration PNEUMONIA

DUETO, OR AS A CONSEQUENCE OF (b) COPD.

DUETO, OR AS A CONSEQUENCE OF (c) Bronchitis - secondary

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☐ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/14/86, 1986, to 12/18/86, 1986, that (I) (we) lost the deceased alive on 12/18/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) the body after death.

22b. SIGNATURE Celiar E. Parra DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Celiar E. Parra 22e. ADDRESS 7122 Harford Road

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 12/20/86 23c. NAME OF CEMETERY OR CREMATORY Greenmount 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland

24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212 25a. DATE REC'D. BY REGISTRAR DEC 22 1986 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 2 and 3 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove yellow papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										86 33671	
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH			3. MONTH		4. DAY		5. YEAR	
Annie Elizabeth BROWN			December 17, 1986						6. HOUR		
									12:38 p.m.		
7. SEX		8. RACE		9. DATE OF BIRTH		10. AGE (IN YEARS LAST BIRTHDAY)		11. IF UNDER 1 YEAR		12. IF UNDER 24 HRS	
Female		White		5 19 10		76		MONTHS DAYS		HOURS MIN.	
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			14. CITIZEN OF WHAT COUNTRY?			15. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			16. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.						Baltimore County MD		
17. CITY OR TOWN OF DEATH			18. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			20. KIND OF BUSINESS OR INDUSTRY		
Rossville			Franklin Square Hospital			Housework			At Home		
21. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			22. INSIDE CITY LIMITS?			23. STREET ADDRESS / ZIP CODE					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN					
Md.			Baltimore			628 South Newkirk St. 21224					
24. FATHER'S NAME			25. MOTHER'S MAIDEN NAME								
Andrew Hartman			Annie Harker								
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			27. SOCIAL SECURITY NO.			28. INFORMANT			29. ADDRESS		
No			217-14-0331 0			Orville T. Brown Jr.			628 S. Newkirk St. 21224		
30. CAUSE OF DEATH (Enter only one cause per line for each part.)										31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Myocardial infarction, cardiogenic shock											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Perforated peptic ulcer											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Chronic obstructive lung disease											
32. DATE OF OPERATION			33. CONDITION FOR WHICH OPERATION WAS PERFORMED			34. AUTOPSY?			35. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
36. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			37. TIME OF INJURY			38. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
39. INJURY OCCURRED			40. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			41. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						STREET CITY OR TOWN COUNTY STATE					
42. I certify that (this hospital) attended the deceased from December 3, 1986, to December 17, 1986, that (I/we) last saw the deceased alive on December 17, 1986, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.											
43. SIGNATURE						44. DEGREE			45. DATE SIGNED		
R. Barrenchia, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
46. PHYSICIAN'S NAME (TYPE OR PRINT)						47. ADDRESS					
R. Barrenchia, M.D.						9000 Franklin Square Drive, 21237					
48. BURIAL, CREMATION, REMOVAL (SPECIFY)			49. DATE			50. NAME OF CEMETERY OR CREMATORY			51. LOCATION		
Burial			12-20-86			Oak Lawn Cemetery			City or Town County State		
									Eastwood, Balto. Co., Md.		
52. FUNERAL DIRECTOR						53. DATE REC'D. BY REGISTRAR			54. REGISTRAR'S SIGNATURE		
Charles S. Zeiler & Son Inc. 6224 Eastern Ave.						DEC 19 1986					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove pages 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME FIRST MIDDLE LAST BARBARA Anne BROWN					2a. DATE OF DEATH MONTH DAY YEAR 12 18 86				
3. SEX FEMALE					4. RACE White				
5. DATE OF BIRTH MONTH DAY YEAR 7 09 33					6. AGE (IN YEARS LAST BIRTHDAY) 53				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD					8. CITIZEN OF WHAT COUNTRY? USA				
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD					10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Exec. Secretary				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital					12. KIND OF BUSINESS OR INDUSTRY				
13a. CITY OR TOWN OF DEATH Towson					13b. COUNTY BALTO.				
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS / ZIP CODE 3810 FORRESTER AVE. 21206				
14. FATHER'S NAME FIRST MIDDLE LAST Adam Reed					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Lutz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 212-30-8335				
17. INFORMANT ADDRESS Elizabeth Gegner 5321 Plainfield Ave. 21206									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure due to</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung with metastases.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>spread of metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Natividad D. de Leon, M.D.					22c. DATE SIGNED 12/18/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON					22e. ADDRESS c/o St. Joseph Hospital, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE Dec 22 1986				
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith					23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.					25a. DATE REC'D. BY REGISTRAR DEC 19 1986				
25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall									

BP

026630 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES Leon BROWN Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12 03 '86			2b. HOUR 3:00P _M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 9 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Messenger	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 1419 Bellona Avenue 21093					
14. FATHER'S NAME FIRST MIDDLE LAST Carl E. Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Lee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-14-8200		17. INFORMANT ADDRESS Marie A. Brown 1419 Bellona Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METABOLIC ACIDOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/06, 19 86, to 12/03, 19 86, that (I) (we) lost saw the deceased alive on 10/03, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Johann F. A. von Franke MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/03/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Johann F.A. von Franke				22e. ADDRESS 6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/86		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Md.	
24. FUNERAL DIRECTOR NAME Chatman-Harris FH 1701 McCulloh Street				25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE Julie Swisher-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 1 and 2, should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of this.

020000000000

CHAMBERLAIN, JOHN H. JR. 1924-03-10

BALTIMORE COUNTY

1100-0001, 1100-0002, 1100-0003

CARLISLE STREET

METABOLIC LABORATORY

RENTAL BILLS



1924-03-10

1924-03-10

1924-03-10

1924-03-10

1924-03-10

1924-03-10

1924-03-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then make return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33674

FOR STATE REGISTRAR			REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE CAMILLA LAST Brundick			2a. DATE OF DEATH MONTH DAY YEAR December 19, 1986	
3. SEX Female			2b. HOUR 4:45 p.m.	
4. RACE White			6. AGE (IN YEARS LAST BIRTHDAY) 77	
5. DATE OF BIRTH MONTH DAY YEAR June 19, 1909			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore Co.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN			12b. KIND OF BUSINESS OR INDUSTRY Hairdresser	
14. FATHER'S NAME FIRST MIDDLE LAST Otto Henry Brundick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Margaret Bauer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-01-9281A	
17. INFORMANT ADDRESS Mrs. Anna M. Thompson, Towson, Md. 21204			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE			21f. DATE SIGNED 12-19-86	
22a. I certify that (this hospital) attended the deceased from <u>December 08</u> , 19 <u>86</u> , to <u>December 19</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>December 19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>Kirk Steptoe, M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Kirk Steptoe, M.D.			22d. ADDRESS 9000 Franklin Square Drive, 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-23-86	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.			25. DATE REC'D. BY REGISTRAR DEC 22 1986	
25. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>				

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR Mabel Jane BulkoDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Mabel J. BULKO

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

2

10

1916

2a. DATE OF DEATH

MONTH

DAY

YEAR

December 18, 1986

2b. HOUR

1:30 a.m.

6. AGE (IN YEARS LAST BIRTHDAY)

70

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Rossville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Franklin Square Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Baker

12b. KIND OF BUSINESS OR
INDUSTRYSchool
Cafeteria

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Dundalk

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

207 German Hill Rd./21222

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Hiram

Willhour

15. MOTHER'S MAIDEN NAME

Laura

MIDDLE

LAST

Wynn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

214/38/2503

17. INFORMANT

ADDRESS

Robert A. Bulko (same as 13e.)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Diabetes MellitusAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that ☒ (this hospital) attended the deceased from September 10, 19 86, to December 18, 19 86, that ☒ (we) last
saw the deceased alive on December 18, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. ☒ (we) did ☒ view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Carol Herbert, M.D.

22e. ADDRESS

9000 Franklin Square Dr., 21237

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/20/1986

23c. NAME OF CEMETERY OR CREMATORY

Gardens of Faith Cem.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Rosedale, Balto., Md.

24. FUNERAL DIRECTOR

Walter Brooks Bradley Inc. Balto., Md. 21222

25a. DATE REC'D. BY REGISTRAR

DEC 19 1986

25b. REGISTRAR'S SIGNATURE

Julia Anderson-Rubner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please mail this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 3, 5, 7A, 13A-E, 17, 18A-E, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

FOR 1-8-87
STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Baby Girl Bumgardner

2a. DATE OF DEATH MONTH DAY YEAR
12 29 86

2b. HOUR
6:10 P.M.

3. SEX F 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR
12 29 86

6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.
YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD.

10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greater Baltimore Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE md. 13b. COUNTY Baltimore 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE
1266 S. Pleasant Valley Rd. 21207

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Distress Syndrome
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extreme Prematurity - 23 weeks
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 hrs.
7 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Left pneumothorax

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from December 29, 1986, to December 29, 1986, that (I) (we) last saw the deceased alive on December 29, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED
Gary Karlowicz MD 12/30/86
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS
Gary Karlowicz, M.D. G.B.MC.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation (release) 12/29/86 GB MC Towson Baltimore md.

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
John E. Adams 6761 N Charles JAN 06 1986 Anna Swenson-Randall

BP

028118 DEC 22 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM A. BURKE		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 20, 1986		2b. HOUR 4:10 a.m.	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 22, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER FT. HOWARD, MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STREET ADDRESS / ZIP CODE 3513 WHITE CHAPEL ROAD 21215		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 3513 WHITE CHAPEL ROAD 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Jackson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST G Harriette Burke		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II	
16b. SOCIAL SECURITY NO. 216 07 2488		17. INFORMANT ADDRESS Allen Burke 3513 White Chapel CLIN. RCDS. VA MEDICAL CENTER, FT. HOWARD, MD.			

II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CA OF PANCREAS WITH METASTASIS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

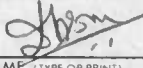
(b)

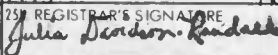
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

CHRONIC ACTIVE HEPATITIS, DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/12 , 19 86 , to 12/20 , 19 86 , that (we) lost saw the deceased alive on 12/20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.			
22b. SIGNATURE 	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/20/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALA DUGGIRALA, M.D.	22e. ADDRESS VA MEDICAL CENTER FT. HOWARD, MD. 21052		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/24/86	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet	23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue		25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE DEC 23 1986 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, item 18 shows any injury, or other traumatic action, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

28111180

DEC 22 1960

26780 DEC 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card page 4. Pages 1 and 2 should be filed with 74 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					86 33678 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edna L. Burkman			2a. DATE OF DEATH MONTH DAY YEAR 12 6 1986		2b. HOUR 3:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 29 1893		
6. AGE (IN YEARS LAST BIRTHDAY) 93		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.		9b. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY		9c. MD.		
10. CITY OR TOWN OF DEATH Catonsville - Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BRIGHTON WOOD NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		
12b. KIND OF BUSINESS OR INDUSTRY Home Maker		13a. STREET ADDRESS / ZIP CODE 309 LUTHER ROAD 21061		13b. CITY OR TOWN GLEN BURNIE		
14. FATHER'S NAME FIRST MIDDLE LAST James Louis Duvall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Frederica White		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 213-74-2031		17. INFORMANT ADDRESS William J. Burkman Jr. Same as 13e		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atrial Fibrillation, Permanent						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-3 , 19 86 , to Present , 19 86 , that (I) (we) last saw the deceased alive on 11-2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE David R. Moreman, M.D.				22c. DATE SIGNED 12-6-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David R. Moreman, M.D.				22e. ADDRESS 5205 East Dr. Arbutus, Md. 21227		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md		24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md				
25a. DATE REC'D. BY REGISTRAR DEC 9 1986				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

1000-3000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#17, per F.H. 1/14/87 kam

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis S. BUTTNER		2a. DATE OF DEATH December 9, 1986		2b. HOUR 5:30a M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 27 18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Local #24
13a. STATE Maryland		13b. COUNTY Balto.	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE 507 Bowleys Quarters Rd. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Michael S. Buttner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anita			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W II		17. INFORMANT E. Jeter Margaret Buttner	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lung and COPD DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 19, 1986, to December 9, 1986, that (I) (we) last saw the deceased alive on December 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ANIL MINOCHA		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL MINOCHA		22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-11-86	23c. NAME OF CEMETERY OR CREMATORY Holly Hills M.P.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		ADDRESS 7401 Belvoir Rd. BALTO. MD 21236		25a. DATE REC'D. BY REGISTRAR DEC 10 1986	
25b. REGISTRAR'S SIGNATURE John Anderson-Randall					

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATE

DHMH - 16 60M 7/84
(VRA 15, 4)



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33681
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
3. DECEASED NAME FIRST MIDDLE LAST VERNON Hooper BYUS, Sr.		12-27-86		12:59 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 20 1897	6. AGE (IN YEARS LAST BIRTHDAY) 89	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) GRMC-6701 N. CHARLES ST.		12a. USUAL OCCUPATION / (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor of	12b. KIND OF BUSINESS OR INDUSTRY Dept. of Education	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Masonic Home, International Cir. 21030	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Anderson Byus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louise Hooper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I 217-05-5574A		17. INFORMANT ADDRESS Marie A. Byus, same as 13e.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSION D/C DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1986, to 12-27-86, that (I) (we) last saw the deceased alive on 12-27-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Libero		DEGREE MD	22c. DATE SIGNED 12/27/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. UBEROI K.S.		22e. ADDRESS GBMC-6701 N. CHARLES ST.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/30/86	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	23d. LOCATION WOODLAWN BALTO. MD.
24. FUNERAL DIRECTOR NAME Martin D. Lawson, 10 W. Padonia Rd., 21093		25a. DATE REC'D. BY REGISTRAR DEC 29 1986	25b. REGISTRAR'S SIGNATURE Julia Swisher-Rodman

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please submit complete papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as "death by injury, or other traumatic event," the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove accompanying papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST OCEY B CAMPBELL					MONTH DAY YEAR 12-20-86				
3. SEX					2b. HOUR				
F					10 58 AM				
4. RACE					5. DATE OF BIRTH				
B					MONTH DAY YEAR 11-12-14				
6. AGE (IN YEARS LAST BIRTHDAY)					7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				
72 YRS					Md				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
					Baltimore County MD				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
Randallstown					Baltimore County General				
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. STATE					13b. KIND OF BUSINESS OR INDUSTRY				
Md					Housewife				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Nicholas Johnson					FIRST MIDDLE LAST Sadie Bagwell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
NO					218-05-7570 D				
17. INFORMANT					ADDRESS				
Deborah Henry					3907 Woodbine Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION -</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
<u>RENAL FAILURE</u>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
					20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-19</u> 19 <u>86</u> , to <u>12-20</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
<u>R. DEPESTRE</u>					12-20-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
R. DEPESTRE					BALTIMORE COUNTY GENERAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					12/24/86				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
Arbutus Memorial Park					Arbutus Md				
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
March Funeral Home West 4300 Wabash Avenue					DEC 23 1986				
					25b. REGISTRAR'S SIGNATURE				
					Julia Davidson-Randall				

10-14-50

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 6 8 5

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Mary Jane Canning					12-30-86				8:25 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 72 HRS	
Female	White	MONTH DAY YEAR 10-13-1896			90	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rossville	Manor Care Rossville Nursing Home				Home Maker				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MD.		Balto.	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	710 DALE Avenue-21206				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST William Ware		FIRST MIDDLE LAST Mary Jane Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
		213-74-5973 216-10-7576B		Mary Jane Etzel - 3638 Chesterfield Ave.-21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe Dementia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 1</u> , 19 <u>86</u> , to <u>Dec 30</u> , 19 <u>86</u> , that (I/we) lost saw the deceased alive on <u>Dec 22</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.									
22b. SIGNATURE <u>Howard H. Bond</u>				DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/31/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard H. Bond, M.D.				22e. ADDRESS 9618 Belair Road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-3-86	Gardens of Faith Cem.			Balto. Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John C. Miller Inc.-6415 Belair Rd.-21206				JAN 5 1987		<u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death. Page 3 may be retained by the hospital or attending physician.

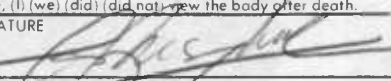
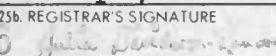
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 3 0 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILSON EDWIN CARPENTER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1986		2b. HOUR 1:25 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 30, 1922		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tech. Writer		12b. KIND OF BUSINESS OR INDUSTRY Motorola	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY WILSON CARPENTER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA HALLMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a RESPIRATORY FAILURE, COS PULMONALE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 26 , 19 86 , to DECEMBER 15 , 19 86 , that (I) (we) last saw the deceased alive on DECEMBER 15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-16-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.V.J. VERGHESE, M.D.				22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Fairview Pres. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wallace Twsp., Chester, PA	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25a. DATE REC'D. BY REGISTRAR DEC 17 1986		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose M. CASSINISI			2a. DATE OF DEATH MONTH DAY YEAR December 18, 1986		2b. HOUR 8:00 a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SIGNATURE AREA) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank Zellers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Devlin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 214 38 4435		17. INFORMANT ADDRESS Joseph Cassinisi, Husband Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding, diffused</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated coagulopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized peritonitis secondary to perforated</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>colon carcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 26</u> , 19 <u>86</u> , to <u>December 18</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 18</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>A. Pidlaon</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Pidlaon, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237				
23a. BURIAL, CREMATION, REMOVAL (S) Burial		23b. DATE 12/22/86		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave 21221		25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Tindon-Pedraza</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a post-mortem examination should be made.

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New York, N.Y.
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Franklin D. Roosevelt
New York, N.Y.
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Franklin D. Roosevelt
New York, N.Y.
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 0 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clarence Caulfield			2a. DATE OF DEATH MONTH DAY YEAR 12-10-86			2b. HOUR 6:20 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 6 98		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
12. CITY OR TOWN OF DEATH Catonsville		13. HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 S. Caton Ave. 21229		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor		15. KIND OF BUSINESS OR INDUSTRY Newspaper				
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Balto.			16c. CITY OR TOWN Catonsville			16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
17. FATHER'S NAME FIRST MIDDLE LAST James P. Caulfield			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Boyle			19. STREET ADDRESS / ZIP CODE 711 Maiden Choice Lane 21228				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		21. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-01-3502		22. INFORMANT ADDRESS Mrs. Muriel B. Caulfield - Same as #13						
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Stroke - Hemorrhagic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None										
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11-24-86 P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE 11-24-86 12-10-86		34. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did not) view the body after death.				
35. SIGNATURE George Hanger		36. DEGREE MD		37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 12-10-86				
39. PHYSICIAN'S NAME (TYPE OR PRINT) George Hanger		40. ADDRESS 3350 Wilbur Dr. Bk								
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		42. DATE 12-10-86		43. NAME OF CEMETERY OR CREMATORY		44. LOCATION CITY OR TOWN COUNTY STATE				
45. FUNERAL DIRECTOR NAME Anatomy Board				46. ADDRESS Balto., Md.		47. DATE REC'D. BY REGISTRAR DEC 15 1986		48. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA L. CAVEY			2a. DATE OF DEATH MONTH DAY YEAR December 5, 1986			2b. HOUR 3:45 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 17, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
12. CITY OR TOWN OF DEATH Catonsville		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY Home		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland			17b. CITY OR TOWN Baltimore			17c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			17d. STREET ADDRESS / ZIP CODE 539 Oella Avenue 21043	
18. FATHER'S NAME FIRST MIDDLE LAST John H. Baer			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Henson							
20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			20b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-34-9711			21. INFORMANT Linda Cavey Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Age</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <u>Cancer of Uterus & Melanoma</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/79</u> , 19 <u>86</u> , to <u>12/5</u> , 19 <u>86</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>12/4</u> , 19 <u>86</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> (did not) view the body after death.										
22b. SIGNATURE <u>Cliff Ratliff</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/5/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cliff Ratliff M.D.						22e. ADDRESS 5772 Westview Mall, Baltimore, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/8/86		23c. NAME OF CEMETERY OR CREMATORY Good Sherherd Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Maryland		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 1630 Edmondson Avenue, Catonsville, MD. 21228						25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME Susie (SUE) B. CHANDLER			2a. DATE OF DEATH MONTH DAY YEAR 12-04-86		2b. HOUR 6:30 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9-29-12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST E. C. Bonniwell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Herman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 223-18-6250 228-01-8843D		17. INFORMANT ADDRESS Frances Faye Bird 806 223rd Street Pasadena, MD.-21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AORTIC STENOSIS, CRITICAL</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>CORONARY ARTERY DISEASE - 2 VESSELS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV. 25</u> 19 <u>86</u> to <u>DEC. 4</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>DEC. 4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Cesar G. Gamba, MD</u>				DEGREE MD		22c. DATE SIGNED 12-4-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR G. GAMBORA, MD				22e. ADDRESS ST. JOSEPH HOSPITAL, TOWSON, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-8-86		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION Baltimore, Maryland STATE		
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Road=21206				25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary A. Chandlee			2a. DATE OF DEATH MONTH DAY YEAR December 27 1986		2b. HOUR 6:00A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 23 1914	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2901 Dunglew Road Apt. 3 21222		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2901 Dunglew Rd. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua T. Dise			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-7258	17. INFORMANT ADDRESS Ralph A. Chandlee Apt. 3 Dundalk 2901 Dunglew Rd 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) urinary tract infection / sepsis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K. Woodrup		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karen Woodrup		22e. ADDRESS FSK MC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec. 28 1986	23c. NAME OF CEMETERY OR CREMATORY Westview Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME 7922 Wise Ave. Dundalk, MD 21222 Duda-Ruck Funeral Home of Dundalk, Inc.			25a. DATE REC'D. BY REGISTRAR DEC 29 1986	25b. REGISTRAR'S SIGNATURE Julia Benson	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILDRED C. CLARK			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 22, 1986		2b. HOUR A.M.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH 10 26 10		6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL		12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE) Model		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store
13a. STATE Maryland	13b. COUNTY Balto.	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 1 Edgedale Rd. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Coleman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruefma Massey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-01-0617		17. INFORMANT ADDRESS Mrs. Ellen Bauer 3815 Yolando Rd. 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Left lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Status epilepticus Upper GI Bleed Alzheimer's Disease					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from December 17, 1986 , to December 22, 1986 , that (1) we last saw the deceased alive on December 22, 1986 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did/did not) view the body after death.					
22b. SIGNATURE Patricia A. Savadel, MD		DEGREE MD		22c. DATE SIGNED 12/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. SAVADEL		22e. ADDRESS 120 SR. PIERRE DR TOWSON MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/30/86		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR 21204 DEC 31 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

Handwritten notes and signatures, including "C. J. ...", "J. ...", and "W. ...".

Large section of handwritten text, mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

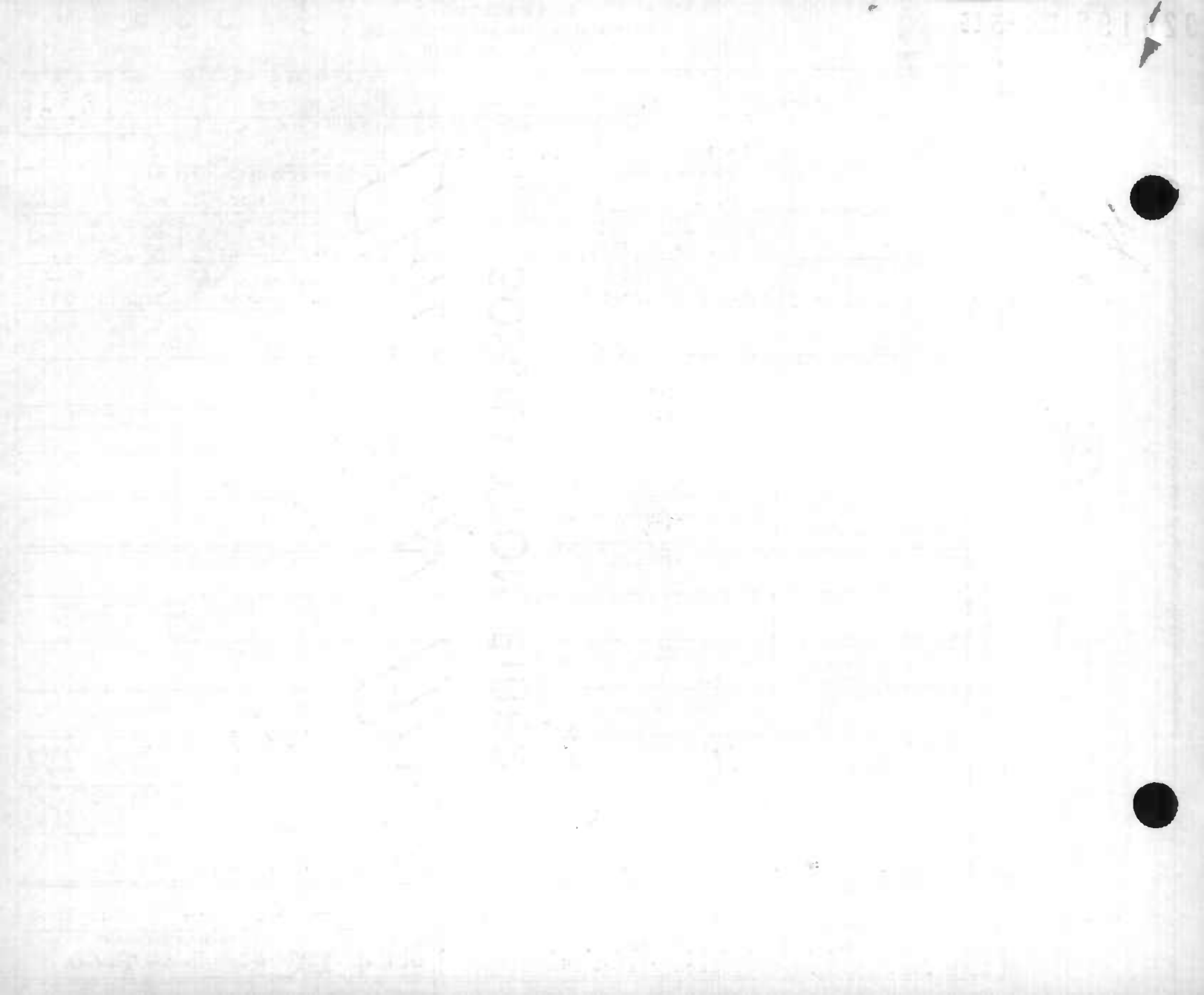
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JAMES A. CLINE				2a. DATE OF DEATH MONTH DAY YEAR December 3, 1986			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6602 Bowman Hill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brewery Worker	
12b. KIND OF BUSINESS OR INDUSTRY National Brewing Co.		13a. STREET ADDRESS / ZIP CODE 6602 Bowman Hill Road 21207					
13b. STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James W. Cline				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie G. Warner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-5680		17. INFORMANT ADDRESS Grace Cline Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic lung Ca Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) COPD							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5772 Westview Mall, Baltimore, MD.			
22a. I certify that (I) (this hospital) attended the deceased from 1986 to 12/3 19 86 , that (I) (we) last saw the deceased alive on 12/3 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Marcellino D. Albuerno M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/86		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Maryland	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228				25a. DATE REC'D. BY REGISTRAR DEC 4 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP



028694 DEC 31 1986

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) **KERMIT CLOUD**

2a. DATE OF DEATH **12/28/86**

2b. HOUR **9:30** M

3. SEX **Male**

4. RACE **White**

5. DATE OF BIRTH **7-21-18**

6. AGE **68** YRS.

7. BIRTHPLACE **Virginia**

7b. CITIZEN OF WHAT COUNTRY? **USA**

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH **BALT. COUNTY** MD.

10. CITY OR TOWN OF DEATH **TOWSON**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION **STELLA MARIS HOSPICE**

12. USUAL OCCUPATION **Sheet Metal Worker**

12b. KIND OF BUSINESS OR INDUSTRY **Westinghouse**

13a. STATE **Maryland**

13b. COUNTY **Baltimore**

13c. CITY OR TOWN **Middle River**

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE **28 Transverse Ave. 21220**

14. FATHER'S NAME **Preston Cloud**

15. MOTHER'S MAIDEN NAME **Nettie Savers**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **Yes**

16b. SOCIAL SECURITY NO. **231 03 5251**

17. INFORMANT **Lassie M. Cloud**

17b. ADDRESS **28 Transverse Ave Balto., MD**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **metastatic renal CA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION _____

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY **12-28-86** HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **12-28-86** to **12/28/86**, that (I) (we) last saw the deceased alive on **12-28-86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **Carla S. Alexander, MD** DEGREE **MD**

22c. DATE SIGNED **12/28/86**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **Carla S. Alexander, M.D.**

22e. ADDRESS **Stella Maris Hospice Dulaney Valley Rd. - Towson, MD 21204**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial**

23b. DATE **12/30/86**

23c. NAME OF CEMETERY OR CREMATORY **Gardens of Faith**

23d. LOCATION CITY OR TOWN COUNTY STATE **Baltimore County Maryland**

24. FUNERAL DIRECTOR **Brzezinski Funeral Home**

24b. ADDRESS **PA 1407 Old Eastern Ave**

25a. DECEASED'S REGISTAR SIGNATURE **Carla S. Alexander**

25b. REGISTAR'S SIGNATURE

BP _____

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 4B above, any injury, or other traumatic event, the medical examiner must be notified at once.

18-00000-1

028715 DEC 31 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REVA YETTA COGAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1986		2b. HOUR 5:15 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 17, 1910		
6. AGE (IN YEARS LAST BIRTHDAY) 76		7. BIRTHPLACE (STATE OR FOREIGN) WEST VIRGINIA		8. CITIZEN OF WHAT COUNTRY? *USA		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JEWISH CONVALESCENT HOME		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER		13. STREET ADDRESS / ZIP CODE 130 SLADE AVE. APT. 102 (21208)		
14. FATHER'S NAME FIRST MIDDLE LAST WOLF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNY SCHLOSS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 220-40-7833		17. INFORMANT WILLIAM C. COGAN		ADDRESS 8504 TOPPING RD. (21208)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest (died in her sleep)</u> 9293 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Heart Dis, decomp</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> Approximate interval between onset and death 10 yrs 33 yrs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diab Mell, cerebral atrophy, Parkinsonism, old stroke, old hip</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/31</u> , 19 <u>53</u> , to <u>Dec 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jonas Cohen M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONAS COHEN		22e. ADDRESS 6702 PARK HEIGHTS AVE. BALTO., MD. (21215)			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/24/86		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, BALTO., MD.	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Friedman-Pandora</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of event.

Dear Sirs:

I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the above.

I am sorry to hear that you are having trouble with the machine. I will try to get it fixed for you as soon as possible.

Very truly yours,

W. H. Smith

Enclosed for you are the parts of the machine that I have ordered. I hope they will be of some use to you.

I am sorry that I cannot do more for you at this time. I will be glad to hear from you again when you have had a chance to try the new parts.

Very truly yours,

W. H. Smith

I am sorry that I cannot do more for you at this time. I will be glad to hear from you again when you have had a chance to try the new parts.

Very truly yours,

W. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card back papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR DEC 23 1986		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alexander Coleman		2a. DATE OF DEATH MONTH DAY YEAR 12 16 86		2b. HOUR 205 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 27, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY SOC. SEC. ADMIN	
13a. STATE MARYLAND		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS COLEMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE Finkelstein		16. STREET ADDRESS / ZIP CODE 6011 STUART AVE. 21209			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-ARMY 060-25-8166		17. INFORMANT ESTATE OF ALEXANDER COLEMAN c/c ALEXANDER R. MARTICK 10 N. CALVERT ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) COPD and CHF. DUE TO, OR AS A CONSEQUENCE OF (c) chronic bronchitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD @ D.M. (3 ALZHEIMERS TYPE Dementia)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/15/86 to 12/16/86 , that (I) (we) last saw the deceased alive on 12/16/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. ENOUR		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ENOUR		22e. ADDRESS BALTIMORE COUNTY GEN. HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY HAR SINAI CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILL BALTO MD	
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO, MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE Julia Tinson	

BP

Received

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028233 DEC 29 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eva			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1986			2b. HOUR 2:27 p_M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 8 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Morgan Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lewis			13e. STREET ADDRESS / ZIP CODE 2027TurkeyPointRoad21221				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-46-6776		17. INFORMANT Mary Jackson				ADDRESS 2027TurkeyPointRd. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) Acute MYOCARDIAL INFARCTION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE Adult Onset Diabetes mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 86 , to 12/20 , 19 86 , that (I) (we) post saw the deceased alive on 12/20 86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Douglas Lawton MD			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas Lawton MD			22e. ADDRESS 9000 Franklin Square Drive, BALTO 21221							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/23/86		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221					25a. DATE REC'D. BY REGISTRAR DEC 24 1986		25b. REGISTRAR'S SIGNATURE Julia Davis			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked "other," show any injury, or other trauma, or other medical condition which must be notified of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 1 (pages 1, 2) and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. (Page 1) should be filed with 72 hours after death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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027638 DEC 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLIFFORD FREDERICK COOK			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 12, 1986		2b. HOUR 7:03A M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 27, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithographer		12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK COOK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALBERTINE BERKLINE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 212 07 3206	
17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES DAYS		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 11, 1986 to DECEMBER 12, 1986 , that (I) (we) lost saw the deceased alive on DECEMBER 12, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wen Shyang Wu		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-12-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WEN-SHYANG WU, M.D.		22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-86		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR DEC 17 1986		25b. REGISTRAR'S SIGNATURE Julia Swinson-Budner	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



027951 DEC 13

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33697

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST LAURA E. COOK		2a. DATE OF DEATH MONTH DAY YEAR 12 11 1886		2b. HOUR 2:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 25 1886		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View and Convalescent Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Augustus John Kuhn Stanley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Krauder		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 212-74-5946		17. INFORMANT Jean Benedict 815 W. Joppa Rd. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. C. Kowalewski MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. C. KOWALEWSKI				22e. ADDRESS 8604 HARFORD RD 21234			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-4-86		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				7401 Belair Rd. ADDRESS BALTO. MD. 21236		25a. DATE REC'D. BY REGISTRAR DEC 4 1986	
25b. REGISTRAR'S SIGNATURE Julia Terison-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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026462 DEC 19

Film G6222 Item 1 12/8/86 rja

FOR STATE REGISTRAR
Per Phone call F.H.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 33098
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Bertha Cooper			2a. DATE OF DEATH MONTH DAY YEAR 12 3 86			2b. HOUR 5:25 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 25 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 505 Park Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 505 Park Ave. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST William Gilimeyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna E. Schwiensberg							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-0604			17. INFORMANT ADDRESS Vernon L. Cooper - same as #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10 June 80</u> to <u>3 December 86</u> , that (I) <u>last</u> saw the deceased alive on <u>29 November 1986</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>yes</u> (did) <u>not</u> view the body after death.										
22b. SIGNATURE <u>Charles O Donnell</u> DEGREE M.D.						22c. DATE SIGNED 12-3-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles O Donnell M.D.						22e. ADDRESS 7501 York Rd. Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-6-86		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Sanderson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.

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029578 JAN 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHERINE Gilpin COOPER			2a. DATE OF DEATH MONTH DAY YEAR 12/29/86			2b. HOUR 7:00 AM				
3. SEX Female		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 11 26 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Hill Gilpin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Hatcherson			11. STREET ADDRESS / ZIP CODE 14310 Cooper Road 21131				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 213-40-8010		17. INFORMANT George Constable				ADDRESS Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute rhabdomyolysis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>86</u> , to <u>12/29</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Bruce Rosenberg MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/29/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE ROSENBERG			22e. ADDRESS 1134 YORK RD. LUTHERVILLE, MD 21093							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/31/86		23c. NAME OF CEMETERY OR CREMATORY St. James Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Monkton, Baltimore, Md.			
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz			ADDRESS Jarrettsville, Md.			25a. DATE REC'D. BY REGISTRAR JAN 05 1987				
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>										

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8633700
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (PRINT OR PRINT)		3. SEX		4. RACE	
Anne (Cremen) Cordle		Female		White	
5. DATE OF BIRTH		6. AGE		7. BALTIMORE CITY OR COUNTY OF DEATH	
May 5, 1912		74 YRS.		Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U. S. A.			
9. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto.		1718 Glen Keith Blvd.		Homemaker	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Loch Raven Village	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Robert Joseph Cremen		Anna Elizabeth O'Neill		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17b. ADDRESS	
219-28-7860		Mrs. Carolyn Stadfeld		21136 Billy Barton Circle	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary of Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>September 6, 1986</u> to <u>December 21, 1986</u> , that (I) <u>lost</u> saw the deceased alive on <u>December 6, 1986</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Paul L. O'Mansky</u>		MD		<u>Dec 23/1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Samuel I. O'Mansky		8405 A Loch Raven Blvd.			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		24 DEC 86		New Cathedral Ceme.	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Baltimore,		Baltimore,		Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. E. Lowell Lemmon Padonia & York Rds.		DEC 23 1986		<u>Julia Twidson Padonia</u>	

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LOW FIBER

DEC 22 1962

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAUDE D. CRAMBLITT			2a. DATE OF DEATH MONTH DEC. DAY 13 YEAR 1986			2b. HOUR M 							
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH JULY DAY 25 YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO. MD.							
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MTVA			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.						13b. COUNTY BALTO. CO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 HILLARY WAY 21030	
14. FATHER'S NAME FIRST ALONZA MIDDLE FORD LAST LEWIS						15. MOTHER'S MAIDEN NAME FIRST CLAUDIA MIDDLE B. LAST MEEKINS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-07-6159		17. INFORMANT FAMILY RECORDS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) multiple peripheral, Vascular insufficiency APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DR. HAN										22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HAN										22e. ADDRESS 95 AQUAHART RD.			
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE DEC. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY CREST LAWN		23d. LOCATION CITY OR TOWN HOWARD CO. COUNTY MD. STATE					
24. FUNERAL DIRECTOR EVANS CHAPEL OF CHIMES, TIMONIA						25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE Julia Deaton-Buchanan					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "the", "in", "on", "at", "to", "from", "by", "with", "without", "under", "above", "below", "between", "among", "amongst", "between", "among", "amongst", "between", "among", "amongst" are visible.]

4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 7 0 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary C. Cross			2a. DATE OF DEATH MONTH DAY YEAR 12 23 86		2b. HOUR 8:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 7 19		
6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.		10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 314 Golf Course Rd. Owings Mills		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Biostatistician		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE 314 Golf Course Rd. 21117		
14. FATHER'S NAME FIRST MIDDLE LAST Charles O. Clemson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gray		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 213-18-1741		17. INFORMANT John E. Cross Jr. (Same as above)		ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stage IV papillary serous cystadenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF of the ovary (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September</u> , 19 <u>75</u> , to <u>December 20</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased <u>alive</u> <u>December 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. McRae Williams</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/29/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. McRae Williams, M.D.				22e. ADDRESS 201 E. University Pkwy. Baltimore 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-24-86		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md.				25a. DATE REC'D. BY REGISTRAR JAN 8 1987			
				25b. REGISTRAR'S SIGNATURE <u>John Anderson-Randall</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



028350 DEC 29 1986

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gladys BERTRUDE Curlander			2a. DATE OF DEATH MONTH DAY YEAR 12 18 86			2b. HOUR 2 A.M.				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06 24 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5914 Falkirk Rd. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Walter B. Cannon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariah Eva Lewis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-46-9906		17. INFORMANT June Alt		ADDRESS 4100 N. Charles St. Baltimore, Md. 21218				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) LARGE BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/17/86 to 12/18/86 , that (I) (we) last saw the deceased alive on 12/18/86 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Atkins			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AHVIE HERSKOWITZ			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.					ADDRESS 6500 York Rd. 21212		25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

1000 50 0830



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 38, allows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 17 86

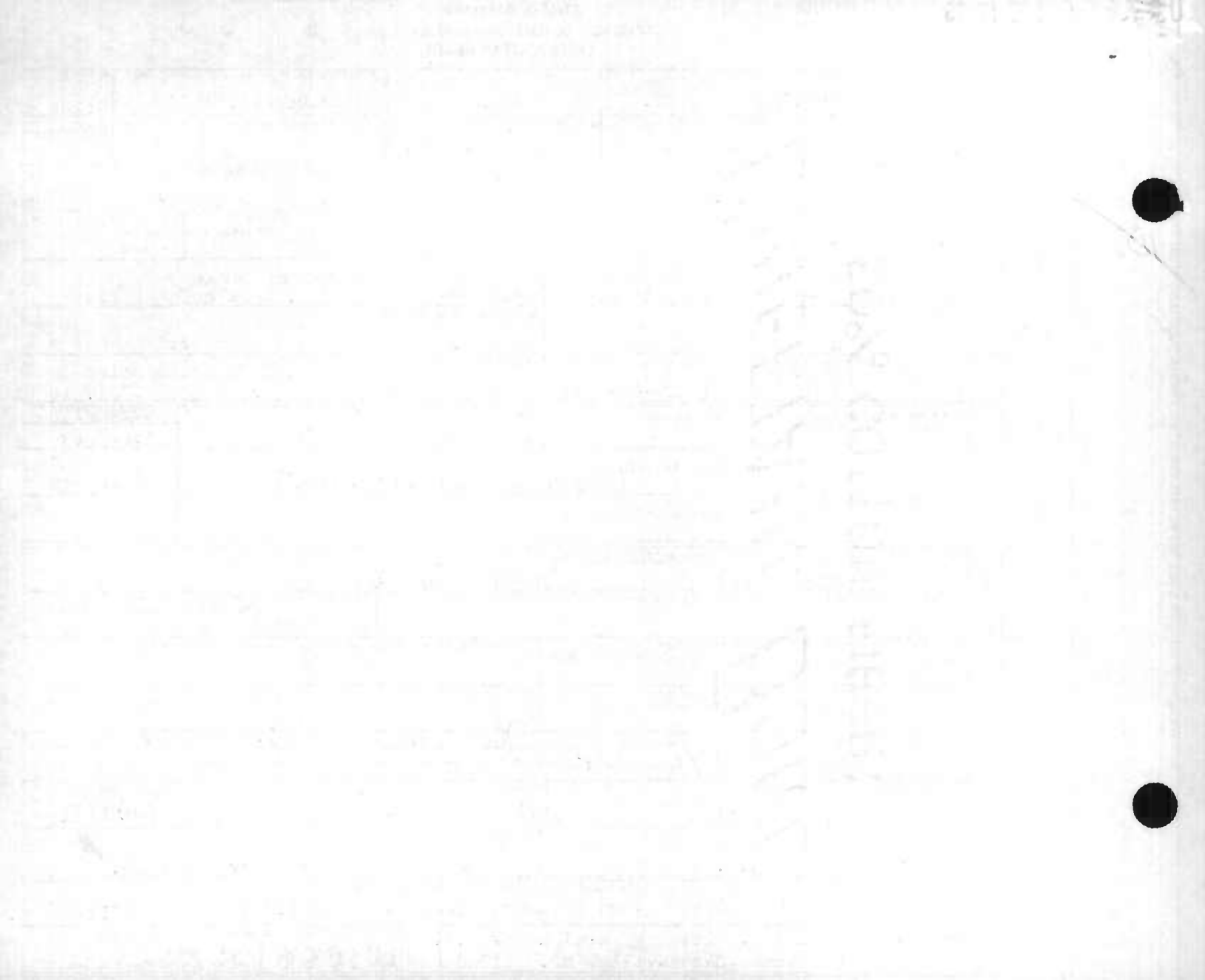
1-
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE E. CURRAN			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1986			2b. HOUR 9:20P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 8, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY BALTO		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 618 N. Bend Road 21229	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Byrne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Hetherington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-4965		17. INFORMANT ADDRESS Virginia Hastie 122 Panorama Drive State College, PA. 16801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 month</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Art CVD</u> (b) <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>76</u> , to <u>Dec</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James Nolan</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/15/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Nolan M.D.				22e. ADDRESS 1 Mallow Hill Road, Baltimore, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leroy H. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228				25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Seiden-Randee</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence K. Daniels			2a. DATE OF DEATH MONTH DAY YEAR December 29, 1986			2b. HOUR M M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 2130 Bauernschmidt Dr.				12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Bach			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Baker			13e. STREET ADDRESS / ZIP CODE 2130 Bauernschmidt Dr. 21221			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 32 4098		17. INFORMANT ADDRESS 2132 Bauernschmidt Dr. Edward Daniels, Son Balto., Md. 21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HIT CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CA of Breast c metas to hip</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/16/81</u> , 19 <u>81</u> , to <u>the present</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased <u>alive</u> <u>10/22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>move the body after death</u> .									
22b. SIGNATURE <u>Mary J. Rombio MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/30/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary J. Rombio MD				22e. ADDRESS 805 FUSELAGE AVE Balto MD 21220					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 1/2/87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Bruzdzinski Funeral Home</u>				ADDRESS PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pandora</u>	

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December 29, 1956

Florence A. Tamm

76

Nov. 23, 1956

white

female

Baltimore County

x

and

Clinton, Md.

Honorable

The Honorable Mr.

James E. Tamm

2130 Ravenwood Dr. S.E.

for

James

Clinton

Maryland

Editor

Each

2130 Ravenwood Dr.

2130 Ravenwood Dr., S.E., Washington, D.C.

to

to the Co., Inc.

Washington County

2130

Editor

2302

Washington County, Inc. 1007 Old Eastern Ave

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 3 3 1 0 0							
1- FOR STATE REGISTRAR		REG. NO.															
2a DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	PM			
Edward		V.		Daubner				12		19	86	6:15		PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		White		8 MONTH 6 DAY 11 YEAR		75 YRS.		MONTHS		DAYS		HOURS		MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
New Jersey		U.S.A.				Baltimore County MD											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY											
TOWSON		Greater Baltimore Medical Center		Professor		College											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE									
Maryland		Baltimore		Lutherville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		30 Bramleigh Rd. 21093									
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
George Daubner		Mary H. Schmidt															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		---		143-22-7455		E.W.Daubner 30 Bramleigh Rd. 21093											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) <u>Acute respiratory distress syndrome</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atherosclerotic cardiovascular disease</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (the hospital) attended the deceased from <u>12/16/86</u> to <u>12/19/86</u> , that (I) (we) last saw the deceased alive on <u>12/19/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Leslie L. Walters</u> DEGREE _____														22c. DATE SIGNED			
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>														12/20/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS													
Leslie L. Walters M.D.				6701 North Charles Street 21204													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		12-23-86		Dulaney Valley		Lutherville Baltimore Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS														25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home 6500 York Road 21212														DEC 30 1986		<u>Julia Davidson-Randall</u>	

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1. Introduction

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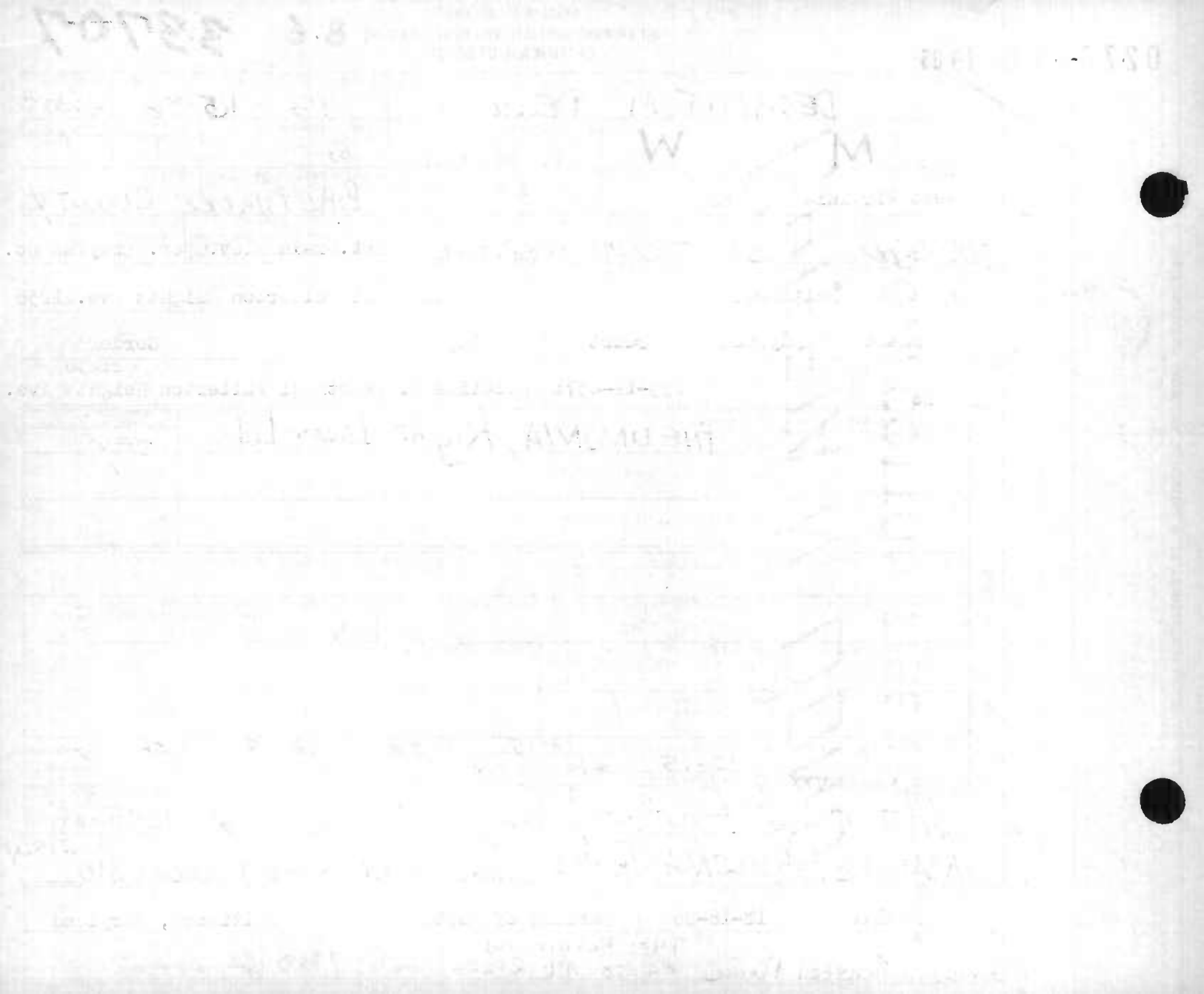
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/B4
(VRA 15, 4)TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical facilities must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 33707	
FOR STATE REGISTRATION										REG. NO.	
1. DECEASED NAME (LAST OR FIRST) DELBERT M. DEARTH					2a. DATE OF DEATH MONTH DAY YEAR 12-15-86			2b. HOUR 4:30 AM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 14 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Grain Elev. Oper.		12b. KIND OF BUSINESS OR INDUSTRY Dreyfus Co.			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Fullerton Heights Ave.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Maywood Dearth					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Voy Corder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 235-12-4571		17. INFORMANT ADDRESS Madeline H. Dearth 41 Fullerton Heights Ave. 21236							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, Right Lower Lobe DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-15 , 19 86 , to 12-15 , 19 86 , that <input checked="" type="checkbox"/> (we) saw the deceased alive on 12-15 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE Maurice B Furlong Jr MD				DEGREE MD				22c. DATE SIGNED 12-15-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURICE B FURLONG JR MD				22e. ADDRESS 7620-YORK ROAD TOWSON MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-18-86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				24b. ADDRESS 7401 Belair Rd BALTO. MD 21236		25a. DATE REC'D. BY REGISTRAR DEC 17 1986		25b. REGISTRAR'S SIGNATURE Julia Tordani-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

027686

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33708

REG. NO.

1. DECEASED NAME (Last, first, middle) George Louis DeGraff			2a. DATE OF DEATH MONTH DAY YEAR 12 16 86		2b. HOUR M
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 8 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH Perry Hall	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4239 Darleigh Rd. 21236		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dredge Captain	12b. KIND OF BUSINESS OR INDUSTRY Great Lake	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dredge & Park Co.	13d. STREET ADDRESS / ZIP CODE 4239 Darleigh Rd. 21236	
FATHER'S NAME FIRST MIDDLE LAST George DeGraff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-0004	17. INFORMANT ADDRESS Louise E. DeGraff 4239 Darleigh Rd. 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL INSUFFICIENCY</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>YEARS</u> <u>MONTHS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED DURING <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> 19 <u>84</u> to <u>12/16</u> 19 <u>86</u> , that (I) (we) lost <u>the</u> deceased alive on <u>12/16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Barry A. Wohl</u>		DEGREE ATTENDING PHYSICIAN	MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>12/16/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry A. Wohl, M.D. (893-0477)		22e. ADDRESS 2003 Rock Spring Rd. Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-18-86	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		41401 Belair Rd. ADDRESS BALTO. MD. 21236	25a. DATE REC'D. BY REGISTRAR DEC 17 1986	25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

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Handwritten text, possibly a date or address, including "10-13-02" and "10-13-02".

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10-13-02

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33709

1. DECEASED NAME (TYPE OR PRINT) Rose M. DeSantis		2a. DATE OF DEATH MONTH December DAY 19 YEAR 1986		2b. HOUR 2:10 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH October DAY 14 YEAR 1894	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Perry Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8641 Saxon Circle		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Perry Hall	
14. FATHER'S NAME FIRST Lawrence MIDDLE Popoli LAST Greener		15. MOTHER'S MAIDEN NAME FIRST Amelia MIDDLE Greener LAST Greener			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-24-8946		17. INFORMANT ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCD - C.H.F. DUE TO, OR AS A CONSEQUENCE OF (b) Dementia due to multi-infarct DUE TO, OR AS A CONSEQUENCE OF (c) & Coelocystia & Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Leukoplakia of Tongue & Hemorrhage Terminal					
19a. DATE OF OPERATION 7/15/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Leukoplakia of Tongue & Hemorrhage Terminal		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NO	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NO		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NO	
22a. I certify that (I) (this hospital) attended the deceased from 7/15/86 to 12/19/86 , that (I) (we) last saw the deceased alive on 12/19/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald W. Mintzer MD		DEGREE MD		22c. DATE SIGNED 12/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald W. Mintzer MD		22e. ADDRESS 3009 Evergreen Ave. Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please include this page in the funeral home's file. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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December 19, 1986

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October 12, 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) CHESTER DIEHL				2a. DATE OF DEATH MONTH DAY YEAR 12 10 86 2b. HOUR 9:37P			
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA		13b. COUNTY Bedford		13c. CITY OR TOWN Bedford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel E. Diehl		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Stiffler		13e. STREET ADDRESS / ZIP CODE Rt. 4, Bedford, 15522			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 174 18 3239		17 INFORMANT ADDRESS Geisel Funeral Home, PA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-10-86 , 19 86 , to 12-10-86 , 19 86 , that (I) (we) lost saw the deceased alive on 12-10-86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE EL-Hennawy		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-10-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EL-Hennawy		22e. ADDRESS S J H.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial		23b. DATE 12/13/86		23c. NAME OF CEMETERY OR CREMATORY Bedford County		23d. LOCATION CITY OR TOWN COUNTY STATE Bedford, PA	
24 FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212				25a. DATE RECEIVED BY REGISTRAR DEC 16 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove center portion. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Hugh B. Dietrich				2a. DATE OF DEATH MONTH DAY YEAR 12-8-86 2b. HOUR 12:05 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12-26-17		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.	
10. CITY OR TOWN OF DEATH Balto. MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIRE FIGHTER		12b. KIND OF BUSINESS OR INDUSTRY CITY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13e. STREET ADDRESS / ZIP CODE 21234 2528 WINDSOR RD.	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD DIETRICH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MURPHY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219-01-4275		17. INFORMANT ADDRESS 21234 Ms. Anna E. Dietrich - 2528 Windsor Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Natividad D. de Leon, M.D. DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON, M.D.				22e. ADDRESS 410 ST. JOSEPH HOSPITAL, TOWSON, MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-12-86		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME Stanley Miller - 7527 Harford Rd. ADDRESS _____				25a. DATE REC'D. BY REGISTRAR DEC 12 1986		25b. REGISTRAR'S SIGNATURE _____	

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REG. NO.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRAR

Salvatore DiGuardo

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SALVATORE DIGUARDO		2a. DATE OF DEATH MONTH DAY YEAR 12-09-86		2b. HOUR 10:00 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 6 1908	
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS 10 MONTHS 10 DAYS		IF UNDER 24 HRS HOURS MIN. 10 HOURS 00 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.		10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER		12b. KIND OF BUSINESS OR INDUSTRY BARBER SCHOOL		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY MD. BALTIMORE	
13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3124 KENTUCKY AVE. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY DIGUARDO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIAN SABATINO		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
16b. SOCIAL SECURITY NO. 215-12-8628		17. INFORMANT PAIAMA DIGUARDO (WIFE) SAME ADDRESS		ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Chronic obstructive lung disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-9-86 19 86 to 12-9-86 19 86 , that (I) (we) lost saw the deceased alive on N/A , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE St. Henry		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-9-86	
22d. PHYSICIAN'S NAME, (TYPE OR PRINT) Adel S. EL-Hennawy		22e. ADDRESS STH					

23a. BURIAL, CREMATION, REMOVAL (SP) ENTOMBMENT		23b. DATE 12/12/86		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Frederick-Penderson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18, there was any injury, or other traumatic event, the medical examiner must be notified of this.

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027159 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 33714

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Evelyn DILL			2a. DATE OF DEATH MONTH DAY YEAR December 11, 1986		2b. HOUR 3:15a M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9-8-1905		6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESLADY.	12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6512 HAZELWOOD Ct. 21237
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. DILL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE E. DUKEHART		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-12-2826		17. INFORMANT ADDRESS Mrs. G. Dowdley Karl - 6512 Hazelwood Ct. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Septic Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from December 10, 1986 , to December 11, 1986 , that (we) last saw the deceased alive on December 11, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ioanna			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/11/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ioanna Gouni, M.D.			22e. ADDRESS 9000 Franklin Sq. Dr., 21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-15-86	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., Md	
24. FUNERAL DIRECTOR NAME Partly, Hill - 7527 Harford Rd.			25a. DATE REC'D. BY REGISTRAR DEC 12 1986		25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page a may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

BP

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TRANSFERS TO THE
GENERAL FUND
18 21-1-2-2

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18 21-1-2-2

026341 DEC 1986

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

STATE OF MARYLAND

8 6

3 3 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BABY BOY DOBRZYKOWSKI		2a. DATE OF DEATH MONTH DAY YEAR 12-02-86		2b. HOUR 846AM	
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12-2-86		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 3 42	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Sparks	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6 Quaker CT sparks MD 21152	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas G Dobrzykowski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deirdre Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac and respiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **Sever prematurity**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-2 , 19 86 , to 12-2 , 19 86 , that (I) (we) last saw the deceased alive on 12-2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Salem Al Naber		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-2-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Salem Al Naber, M.D.		22e. ADDRESS 7620 York Road Towson MD 21204	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Hosp Dispo.	23b. DATE 12-2-86	23c. NAME OF CEMETERY OR CREMATORY -----	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS St Joseph Hospital 7620 York Rd Towson 21204		25a. DATE REC'D. BY REGISTRAR DEC 5 1986	25b. REGISTRAR'S SIGNATURE Towson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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2020 COLLECTION FILES

TRAVELING DOWD



28690 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **86 33716**

1. DECEASED NAME (TYPE OR PRINT) Irma Adell DOCHTERMAN			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1986		2b. HOUR 12:15p
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1923	6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 309 George Ave. 21221
14. FATHER'S NAME FIRST MIDDLE LAST George Wagner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Heintz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 58 7928	17. INFORMANT ADDRESS Charles Dochterman, Son Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic breast carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 24, 1986 to December 24, 1986 , that (we) last saw the deceased alive on December 24, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Isadore A. Feldman		DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/24/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Isadore A. Feldman		22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 12/27/86	23c. CEMETERY Schwartz Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE 1st United Evang. Luth Ch. Baltimore Md.		
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home		25a. DATE RECD. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE John D. ...	

BP

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Housewife	Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital
Home	Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital
15311	15311	15311	15311

Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital
Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital
Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital	Franklin Co. Hospital

12/27/86 Jan United States ...

12/27/86 Jan United States ...

029346 JAN-1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST Linda				MIDDLE C.				LAST Dodge				20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR				2b. HOUR			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 30 39		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 12-30 1986				7d. HOUR 8:39 p.m.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD											
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Randallstown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 8801 Sonya Road 21133							
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth S. Rowe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Coe																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 301-34-9952				17. INFORMANT Mr. Weaver Dodge 8801 Sonya Road Randallstown, Maryland 21133															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertrophic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Fatty Liver & Obesity																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 12-31-86											
EXAMINER'S NAME (TYPE OR PRINT)				Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md.				21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/5/87				23c. NAME OF CEMETERY OR CREMATORY Fostoria Fountain Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Fostoria Hancock Ohio											
24. FUNERAL DIRECTOR NAME Loring Byers				ADDRESS 8728 Liberty Road Randallstown, MD. 21133				25a. DATE REC'D. BY REGISTRAR JAN 5 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DOUBT IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10.3, RETURN FILED FOR OUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))



028381 DEC 29 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8633118
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES VINCENT DOLAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 19, 1986			2b. HOUR NOON M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 28, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH 21204		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8356 LOCH RAVEN BLVD. 21204				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISPATCHER.		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN 21204		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8356 LOCH RAVEN BLVD. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK DOLAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET KIMMITT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-10-9306		17. INFORMANT ADDRESS M. LORETTA DOLAN 21204 8356 LOCH RAVEN BLVD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure and arrested</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.H.D., chronic heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.H.D. & diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110: <u>Renal failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u> <u>20+ yrs</u>	
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>N/A</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19 <u>76</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>N/A</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <u>N/A</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET <u>N/A</u> CITY OR TOWN COUNTY STATE					
22a. I certify that (i) this hospital attended the deceased from <u>7/26/76</u> to <u>12/19/86</u> , that (ii) (we) last saw the deceased alive on <u>12/19/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>P. C. Kahle M.D.</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/19/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PONCHA C. KAHLE, M.D.				22e. ADDRESS LOCH RAVEN BLVD. 21204 296-9575					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 22, '86		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GAR.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.		25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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8 JAN -6 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 3 3 / 1 9

1. DECEASED NAME (TYPE OR PRINT) First: <u>Roland</u> Middle: <u>J.</u> Last: <u>DUFOUT</u>			2a. DATE OF DEATH MONTH: <u>12</u> DAY: <u>25</u> YEAR: <u>1986</u>		2b. HOUR <u>10:45 PM</u>
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH: <u>8</u> DAY: <u>17</u> YEAR: <u>1941</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>45</u> YRS.		IF UNDER 1 YEAR MONTHS: _____ DAYS: _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Canada</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.		
10. CITY OR TOWN OF DEATH <u>Randallstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore County General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Sales</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <u>Maryland</u>	13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Randallstown</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>10642 Liberty Road 21133</u>	
14. FATHER'S NAME First: <u>Oliver</u> Middle: _____ Last: <u>Dufault</u>			15. MOTHER'S MAIDEN NAME First: <u>Dora</u> Middle: _____ Last: <u>Dufault</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>047-30-6881</u>	17. INFORMANT <u>Mrs. Melba Dufault</u> ADDRESS <u>10642 Liberty Road Randallstown, MD. 21133</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Electromechanical Dissociation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary artery Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____		
22a. I certify that (I) (this hospital) attended the deceased from <u>12-25</u> , 19 <u>86</u> , to <u>12-25</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William J. Chiracus M.D.</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William J. Chiracus M.D.</u>			22e. ADDRESS <u>Balt. County General Hosp</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>12-30-86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Mound Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Creston</u>	COUNTY <u>Wayne</u> STATE <u>Ohio</u>
24. FUNERAL DIRECTOR <u>Loring Byers Funeral Directors, Inc.</u> NAME ADDRESS <u>8728 Liberty Road Randallstown, MD. 21133</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 5 1987</u>	25b. REGISTRAR'S SIGNATURE <u>Lita Anderson-Rudner</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be issued within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. The certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 7 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Dorsey DULANEY			2a. DATE OF DEATH MONTH DAY YEAR December 8, 1986			2b. HOUR 3:00A _M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 26, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH Putty Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4 Whitelaw Place Apt TD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY C & P Tele.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Putty Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4 Whitelaw Place 21236	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Dulaney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Anastasia				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-56-5776		17. INFORMANT ADDRESS Baltimore, MD 21236 Barbara L. Dulaney 4 Whitelaw Pl Apt TD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metas Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Metanoma</u>		5 months	
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>86</u> , to <u>Dec 9</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Nov 11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Kathy J. Hellsour MD</u> DEGREE 22c. DATE SIGNED <u>12/9/86</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kathy Hellsour, M.D.				22e. ADDRESS Baltimore,, Maryland Johns Hopkins Hospital Oncology Cntr.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec 11, 86		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD.	
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 710 Belair Road Baltimore, MD 21206				25. DATE REC'D BY REGISTRAR DEC 10 1986 <u>Julia D. Hellsour</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 / 2 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Nick Dragonuk Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 16 1986			2b. HOUR M M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 8 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			10. MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3701 Burnmont Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Manager		12b. KIND OF BUSINESS OR INDUSTRY Ben Franklin		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3701 Burnmont Ave. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Dragonuk				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Kotlowski				16. MRS. EILEEN M. DRAGONUK 21133		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. ADDRESS 3701 Burnmont Ave. Randallstown Maryland		17b. ADDRESS 21133		17c. ADDRESS 21133		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HASCU</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <u>John J. Darrell</u> attended the deceased from <u>11/70</u> , 19____, to <u>12/8/86</u> , 19____, that (I) <u>XXX</u> lost saw the deceased alive on <u>12/8/86</u> , 19____, and that in (my) <u>XXX</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>XXX</u> (did not) view the body after death.										
22b. SIGNATURE <u>J. Darrell, M.D.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Darrell, M.D.			22e. ADDRESS 9017 Liberty Road Randallstown, Maryland 21133							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-19-86		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.			ADDRESS 8728 Liberty Rd. Randallstown, MD 21133			25a. DATE REC'D. BY REGISTRAR DEC 18 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

027012 000 1000

December 3, 1952

John Allen Thompson Jr.

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Room 5 1113

Providence

File

Providence County

021

100-1000

See Page 11

Providence, Rhode Island

3701 Bureau Ave.

Providence

2113

3701 Bureau Ave.

X

Providence

100-1000

Providence

John Allen Thompson

Providence, Rhode Island

2113

3701 Bureau Ave.

213-18-8821

File

File

Providence, Rhode Island

3701 Bureau Ave.

2113

3701 Bureau Ave.

Providence, Rhode Island

213-18-8821

027012 000 1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33722

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN E. DREYER, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12/12/86			2b. HOUR 7:31 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 17 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. - Sales	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY BALTO		13c. CITY OR TOWN TOWSON	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Dreyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 128-05-7281		17. INFORMANT ADDRESS Mr. Carl L. Dreyer 9915 Marilynn Rd. 21128			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF

(b)

Direct

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital)) attended the deceased from <i>Aug 1986</i> to <i>Dec 17 1986</i> . I (we) last saw the deceased alive on <i>Dec 17 1986</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did (did not) view the body after death.							
22b. SIGNATURE <i>Benjamin K. Yarkoff, MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin K. Yarkoff, MD				22e. ADDRESS 7600 Oslen Dr. Towson, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-86		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1986	
				25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove supporting papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

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Refugee Center

Refugee - Relief

UNITED STATES DEPARTMENT OF JUSTICE

IMMIGRATION AND NATURALIZATION SERVICE

FOUR

Henry Street

Room



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33723

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leland A. Eaton			2a. DATE OF DEATH MONTH 12 DAY 26 YEAR 86			2b. HOUR 5A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 21 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) (78) 78 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY MD Ship Yard		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 729 Tolna Street 21224		
14. FATHER'S NAME FIRST Ogle MIDDLE Tilghman LAST Eaton			15. MOTHER'S MAIDEN NAME FIRST Sara MIDDLE Emilia LAST Edenfield								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-09-2011			17. INFORMANT ADDRESS Stella T. Eaton Same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Liver metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma colon										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal failure											
19a. DATE OF OPERATION 12/7/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/29/86 , 19 86 , to 12/26 , 19 86 , that (I) (we) lost saw the deceased alive on 12/26/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. JON S. SURECHAMBER			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/26/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JON S. SURECHAMBER			22e. ADDRESS Franklin Square Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-29-86		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE DEC 29 1986					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified by phone.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33724

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH J. EDWARDS			2a. DATE OF DEATH MONTH DAY YEAR December 2, 1986			2b. HOUR 7:50 A M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 31 20		6 AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.				
10 CITY OR TOWN OF DEATH Butler		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3334 Butler Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 522 Baltimore Court 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Arlett F. Edwards			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Shelton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT Mrs. Louise C. Edwards		ADDRESS Same as 13e				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF

(c) Smoking

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Dec 2 1986			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19 86</u> to <u>Dec. 2 19 86</u> , that (I) (we) last saw the deceased alive on <u>Dec 2 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen Laiken</i>				DEGREE MD.		22c. DATE SIGNED 12/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Laiken, MD.				22e. ADDRESS 6805 York Road Baltimore, Md. 21212			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/3/86		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Balto. Balto. Md.	
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Swenson-Randall</i>	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33725

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Claggett, Robert Elwood			2a. DATE OF DEATH MONTH DAY YEAR 12 30 86		2b. HOUR 7:55a M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06/ 25/31		6. AGE (IN YEARS LAST BIRTHDAY) 55	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Firefighter	12b. KIND OF BUSINESS OR INDUSTRY Balto. Co.	
13a. STATE Md			13b. COUNTY Carroll	13c. CITY OR TOWN New Windsor	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Percy Claggett			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Peregoy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea	17. INFORMANT Mrs. Romanie V. Claggett		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Migratory thrombo embolism</u>		2 weeks			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>squamous cell lung carcinoma</u>		unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Superior vena cava syndrome and esophageal stricture</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>December 16</u> , 19 <u>86</u> , to <u>December 30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>December 30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If death did not occur, do not view the body after death.)					
22b. SIGNATURE <u>S. Glasser</u>		DEGREE MD		22c. DATE SIGNED 12/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Glasser, M.D.		22e. ADDRESS G.B.M.C.			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial	23b. DATE 01/02/87	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home, 3631 Falls Rd. 21211		25a. DATE REC'D. BY REGISTRAR 11 JAN 2 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Swenson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place vehicles carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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